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ABSTRACT

The Special Committee on Aging, established in 1961 by Senate Resolution 33, Eighty-seventh Congress, was charged with making a full and complete study and investigation of problems and opportunities of older people, including problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing, and, when necessary, of obtaining care or assistance. The committee has examined "the administration strategy for cutbacks in aging"; "immediate and long-range directions in social security"; medicare and proposed national health insurance plans; nursing homes; employment problems related to recession; housing ligislation; the Older Americans Act; training, research, and education; transportation; and, volunteer and community service by the elderly. Recommendations are made for legislative action and change in administrative policies. Also included are "Minority Views" and five "Appendices": "Analysis of Employee Retirement Income Security Act of 1974," Highlights of the study "The Myth and Reality of Aging in America" conducted by Louis Harris and Associates for the National Council on the Aging, Inc., "New Federalism and Aging," "Reports from Federal Departments and Agencies," and "Committee Hearings and Reports." (JM)

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ED109275

94th Congress
1st Session

SENATE

Report
No. 94-250

DEVELOPMENTS IN AGING: 1974 AND JANUARY-APRIL 1975

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

PURSUANT TO

S. RES. 267, MARCH 1, 1974

Resolution Authorizing a Study of the Problems of the Aged and Aging

TOGETHER WITH

MINORITY AND SUPPLEMENTAL VIEWS

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LETTER OF TRANSMITTAL

JUNE 13, 1975.

Hon. NELSON A. ROCKEFELLER,
President of the Senate,
Washington, D.C.

DEAR MR. PRESIDENT: As required under Senate Resolution 267, agreed to March 1, 1974, I am submitting to you the annual report of the Senate Special Committee on Aging, "Developments in Aging: 1974 and January-April 1975."

Publication has been delayed this year to allow some discussion of major new developments in the field of aging. Additional time was also required for completion of minority views.

Senate Resolution 62, pending before the Committee on Rules and Administration, authorizes the committee to continue inquiries and evaluations of issues on aging. This includes not only those of age 65 and beyond but others who find that advancing years affect their lives in one way or another.

On behalf of the members of the committee and its staff I want to extend my thanks to the officers of the Senate for the cooperation and courtesies extended to us.

Sincerely,

FRANK CHURCH, *Chairman.*

SENATE RESOLUTION 267, 93d CONGRESS 2d SESSION

Resolved, That the Special Committee on Aging, established by S. Res. 33, Eighty-seventh Congress, agreed to on February 13, 1961, as amended and supplemented, is hereby extended through February 28, 1975.[1]

SEC. 2. (a) The committee shall make a full and complete study and investigation of any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing, and, when necessary, of obtaining care or assistance. No proposed legislation shall be referred to such committee, and such committee shall not have power to report by bill, or otherwise have legislative jurisdiction.

(b) A majority of the members of the committee or any subcommittee thereof shall constitute a quorum for the transaction of business, except that a lesser number, to be fixed by the committee, shall constitute a quorum for the purpose of taking sworn testimony.

SEC. 3. (a) For purposes of this resolution, the committee is authorized from March 1, 1974, through February 28, 1975, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to hold hearings, (3) to sit and act at any time or place during the sessions, recesses, and adjournment periods of the Senate, (4) to require by subpena or otherwise the attendance of witnesses and the production of correspondence, books, papers, and documents, (5) to administer oaths, (6) to take testimony orally or by deposition, (7) to employ personnel, (8) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable basis the services of personnel, information, and facilities of any such department or agency, and (9) to procure the temporary services (not in excess of one year) or intermittent services of individual consultants, or organizations thereof, in the same manner and under the same conditions as a standing committee of the Senate may procure such services under section 202(i) of the Legislative Reorganization Act of 1946.

(b) The minority shall receive fair consideration in the appointment of staff personnel pursuant to this resolution. Such personnel assigned to the minority shall be accorded equitable treatment with respect to the fixing of salary rates, the assignment of facilities, and the accessibility of committee records.

SEC. 4. The expenses of the committee under this resolution shall not exceed $415,000,[2] of which amount not to exceed $15,000 shall be available for the procurement of the services of individual consultants or organizations thereof.

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[1] Agreed to Mar. 1, 1974.

[2] S. Res. 13, agreed to on Jan. 27, 1975, provided $16,000 in supplemental funds for committee business.

SEC. 5. The committee shall report the results of its study and investigation, together with such recommendations as it may deem advisable, to the Senate at the earliest practicable date, but not later than February 28, 1975. The committee shall cease to exist at the close of business on February 28, 1975.[2]

SEC. 6. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee.

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[2] S. Res. 111, agreed to March 17, 1975, extended the committee through May 31, 1975. S. Res. 62, the continuing authority for the committee for 1975, is pending before the Committee on Rules and Administration.

PREFACE

Older Americans are waging a daily struggle against the high cost of living.

That fact was documented in last year's annual report by this committee.

It is documented again in this report, which shows how rises in rents and property taxes, utility bills, transportation costs, health charges, and food prices are hitting the elderly even harder than was the case a year ago.

In addition, the elderly are faced by another difficulty: a determined and persistent effort by the present administration to cut back on programs essential for the well-being of our senior population.

This administration attitude is certainly not new. Previous annual reports have told, in some detail, of earlier efforts to gut or significantly reduce Federal commitments on aging.

But in 1974 and so far in 1975, administration negativism has flared up in new and significant ways.

Of greatest concern was the administration position calling for a reduction in a Social Security benefit due in July. That increase was authorized by a 1972 law which established a cost-of-living adjustment mechanism meant to assure, once and for all, that Social Security could be increased as a matter of course when triggered by higher living costs. The increase due in July under terms of the 1972 law, as amended, will be 8 percent. But the Secretary of Health, Education, and Welfare has vehemently insisted that the Congress should pass a law providing only 5 percent.

The Secretary has never convinced me there is a real rationale for his proposal; he certainly has never persuaded me that Social Security recipients don't *need* the full 8 percent. Early in the year, therefore, I introduced a resolution expressing congressional disapproval of the 5 percent proposal. More than a majority of Senators joined me; on May 6 the Senate passed it. HEW Secretary Caspar Weinberger, even then, maintained his position. Grudgingly, he announced on May 15 that the administration would obey the law; the Social Security checks due in July will indeed reflect an 8-percent increase.[1] But the Secretary also denounced the Congress for insisting that even this inadequate relief be given.

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[1] The *Los Angeles Times*, on May 16, described Secretary Weinberger as critical of the Congress for not limiting the mandated Social Security benefit increase to 5 percent. It also quoted him as saying that the $2.2 billion difference between an 8 percent and 5 percent increase would be "a substantial addition to the already large Federal budget deficit." Senator Church—sponsor of a bill (S. 3143) to remove the Social Security Administration from the Department of Health, Education, and Welfare—has been critical of the current practice of including Social Security payments in the "unified budget" of the Federal Government. He argues that Social Security payments are almost completely financed from trust funds and should not be included in general revenue operations.

The Social Security position is just one of many disturbing administration actions described in the following report. Its chapters tell of proposed assaults on Medicare, of efforts to cut funds already appropriated for the Older Americans Act, of continuing administration resistance to genuine nursing home reform, and reluctance to implement a desperately needed program to provide housing for the elderly, just to mention a few. (See chapter I for a summary of what is described as an administration strategy of cutbacks on aging, and individual chapters for discussion of specific items in greater detail.)

It becomes clear that the administration is asking the Congress to take unacceptable actions and then blaming the Congress when Congress will not accept them.

Perhaps the administration is indulging in a game of budgetary politics, making impossible requests in the name of budget-cutting solely for the purpose of saying that Congress, by rejecting them, is increasing the deficit.

Or perhaps the administration is genuinely blind to the real and desperate problems faced by so many older Americans.

Whatever the reasons, the administration is failing to perform one of its most important functions: to act as an advocate on behalf of people.

The Congress, concerned as its Members are about the mounting Federal budget and accompanying deficits, must exercise careful judgment in making its decision on national priorities. It must steer a balanced course: refusing to accept cutbacks which in the long run cost more than they save, and yet looking for genuine economies wherever they may be found or developed.

Despite administration-congressional conflicts on several major issues related to aging, the following report discusses encouraging progress on a number of important fronts. It notes, for example, that the Older Americans Act appears to be on the verge of extension and improvement. There now appears to be more momentum than ever before for nursing home reform and for other forms of care and assistance intended to reduce institutionalization. Legislative enactments related to transportation are at an all-time high, even though there is reason for concern about delays in implementation. (Additional examples of proud congressional directives, followed by lags in actual performance by the executive branch, will be found frequently in the following pages.)

For all of the frustrations, it is encouraging to see very direct evidence that increasing numbers of Americans care—and care deeply—about issues related to aging.

In many communities, retired persons are organizing into action groups intended to make life more satisfying for people in the later years of life. Part-time, paid seniors are putting their talents to good use in the service of others, and Congress is now considering a broadening of such community service programs. Participants in the Retired Senior Volunteer Program have a spirit which inspires me every time I encounter RSVP firsthand. Area agencies on aging are now at work in more than 400 locales; they are struggling with insufficient resources, but they are devoting full-time attention to community action and coordination. And people are talking more about aging; newspapers and television carry stories not only about the problems that come with age but also about the achievements of aging people.

There *is* progress being made, the kind of progress which comes with understanding.

And understanding, after all, is a precious commodity. It was helped along in 1971 with a White House Conference on Aging. It may be helped along once again with a similar conference in 1981, since such national assemblages traditionally take place every 10 years. But 1981 is a long time from now, and it may well be that we should not wait 10 years for another look at where we are. For that reason, I hope that readers of this report pay special heed to its final chapter. There, it is pointed out that the year 1976 will be mid-way between White House Conferences on Aging. The chapter asks whether some productive action should be taken next year to mark the fifth anniversary of the 1971 conference, and it asks for ideas about how this should be done. Personally, I join in asking for suggestions. It seems to me that a miniature or repeat version of the 1971 conference would do little good at this point; we still have a long way to go before we come anywhere near fulfilling recommendations made *then*. But some form of stocktaking could be useful in 1976. The questions are: what form should it take, and how can it take place without diverting energy and resources from other important activities?

Answers to those questions are needed. Nineteen hundred and seventy six, the year of the National Bicentennial celebration, could also be a year in which important issues related to our national future could be answered or at least faced up to more clearly than they now are. That is true of problems affecting all age groups. It is especially true of those that now so seriously trouble so many older persons in this Nation.

FRANK CHURCH,
Chairman, Special Committee on Aging.

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EVERY TENTH AMERICAN[1]

At the turn of the century, there were 3 million older Americans—those aged 65 or over (65+)—comprising 4 percent of the total population or every twenty-fifth American. As of mid-1974, almost 22 million older persons made up 10 percent of the total civilian resident population—every tenth American.

The largest concentrations of older persons—12 percent or more of a State's total population—occur in 8 States (Florida, Arkansas, Iowa, Kansas, Nebraska, Missouri, South Dakota, and Oklahoma).

New York, California, Pennsylvania, Florida, Illinois, Texas, and Ohio each have more than a million older people. California and New York will each have more than 2 million persons aged 65+ within a year or two.

A quarter of the Nation's older population lives in just three States (New York, California, and Pennsylvania). Adding five more States (Florida, Illinois, Texas, Ohio, and Michigan) brings the eight-State total equal to half the older people in the United States. It takes 11 more States (New Jersey, Massachusetts, Missouri, Indiana, Wisconsin, North Carolina, Minnesota, Tennessee, Georgia, Virginia, and Alabama—a total of 19) to account for three quarters of the older population and an additional 11 (a total of 30) to include 90 percent. The remaining 10 percent of the 65+ population lives in the remaining 21 States.

What is this population like, and how does it change?

GROWTH IN NUMBERS

During the 70 years between 1900 and 1970, the total population of the United States grew to almost 3 times its size in 1900 while the older part grew to almost 7 times its 1900 size—and is still growing faster than the under-65 portion. Between 1960 and 1970, older Americans increased in number by 21 percent as compared with 18 percent for the under-65 population. Greatest percentage growth (a third or more) occurred in Arizona, Florida, Nevada, Hawaii, and New Mexico. Florida, with considerable in-migration of elderly, had the highest proportion of older people in 1970, 14.5 percent (estimated 15.8 percent in 1974), while New York had the largest number of older people in 1974, 1,998,000.

TURNOVER

The older population is not a homogeneous group nor is it static. Every day approximately 4,000 Americans celebrate their 65th birthday; every day approximately 3,000 persons aged 65+ die. The net increase is about 1,000 a day or 350,000 a year but the 4,000 "newcomers" each day are quite different from those already 65+ and worlds apart from those already centenarians who were born during or shortly after the Civil War.

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[1] Prepared by Herman B. Brotman, consultant to the Special Committee on Aging, United States Senate, and former Assistant to the Commissioner on Aging.

AGE

As of mid-1974, most older Americans were under 75 (62 percent); half were under 73; and more than a third (36 percent) were under 70. Between 1960 and 1974, the population aged 65 through 74 increased 23 percent but the population aged 75+ increased 49 percent. More than 1.7 million Americans are 85 years of age or over. Accurate data on the number of centenarians is not available but well over 7,000 persons who produced some proof of age are 100+ and receiving social security benefit payments.

HEALTH

Eighty-two percent get along quite well on their own. While only 14 percent have no chronic conditions, diseases, or impairments of any kind, the vast majority that do have such conditions still manage by themselves. Older individuals are subject to more disability, see physicians 50 percent more often, and have about twice as many hospital stays that last almost twice as long as do younger persons.

In fiscal year 1974, per capita health care costs for older Americans came to $1,218, 3.7 times the $330 spent for each under-65 person. $573 went for hospital care, $182 for physician services, $39 for other professional services, $103 for drugs, $289 for nursing home care, and $32 for other items. Older people represent some 10 percent of the population but account for 30 percent of personal health care expenditures. Of the health care costs for older persons, about $734 of the $1,218 total (slightly over 60 percent) came from public programs resources of all kinds. Medicare covered 38.1 percent (about $465) of the total costs per older person, a continuation of the decreasing role of medicare.

PERSONAL INCOME

Older persons have less than half the income of their younger counterparts. In 1973, half of the families headed by an older person had incomes of less than $6,426; the median income of older persons living alone or with nonrelatives was $2,725. Some 3.4 million or just over a sixth of the elderly live in households with incomes below the official poverty threshold for that kind of household. This was a considerable improvement over the close to 5 million in 1970 and results from the increases in social security benefits. Women and minority aged are over-represented among the aged poor. Many of the aged poor became poor after reaching old age because of the reduction in income from earnings with retirement from the labor force. About half of the aged couples could not afford the costs of the theoretic retired couple budget prepared by the Bureau of Labor Statistics for a "modest but adequate" standard of living.

EXPENDITURES FOR CONSUMPTION

Older Americans spend proportionately more of their income on food, shelter, and medical care and less on other items in a pattern generally similar to that of other low income groups. Persons living on fixed incomes are hit hard by price inflation and command little potential for personal adjustment of income. Even formulas that adjust retirement payments for changes in price indices are of only partial assistance since they bring increases well after the fact and older people have little in savings to carry them over until income levels are increased to catch up.

LIFE EXPECTANCY

Based on death rates in 1973, average life expectancy at birth was 71.3 years; 67.6 for men but close to 8 years longer or 75.3 years for women. At age 65, average remaining years of life were 15.3; 13.1 for men but 4 years longer or 17.2 years for women. The 27-year increase in life expectancy since 1900 results from the wiping out of most of the killers of young people—much less improvement has occurred in the upper ages when the major killers become the chronic conditions. More people now reach old age but, once there, they do not live much longer than did their ancestors who reached such age in the past.

SEX RATIOS

As a result of longer life expectancy, most older persons are women—12.8 million as compared to 9 million men in mid-1974. Between ages 65 and 74, there are 130 women per 100 men; after 74, there are 169. For the 85+ group, there are two women for every man. The average for the total 65+ population is 143 women per 100 men.

MARITAL STATUS

In 1974, most older men were married (6.7 million or 79 percent) but most older women were widows (6.3 million or 52 percent). There are five times as many widows as widowers. Of the married men, almost 40 percent have under-65 wives. In 1971, among the 2.2 million marriages of persons of all ages, there were over 20,000 brides and almost 41,000 grooms aged 65+. For about 7 percent of these brides and 5 percent of these grooms it was a first marriage.

EDUCATIONAL ATTAINMENT

In 1974, half of the older Americans had not completed one year of high school. About 2.5 million older people were "functionally illiterate," having had no schooling or less than 5 years. About 7 percent were college graduates.

LIVING ARRANGEMENTS

In 1974, more than 8 of every 10 older men but only 6 of every 10 older women lived in family settings; the others lived alone or with nonrelatives except for the less than one in 20 who lived in an institution. About three-quarters of the older men lived in families that included the wife but only one-third of the older women lived in families that included the husband. More than a third of all older women lived alone. More than 3 times as many older women lived alone or with nonrelatives than did older men.

PLACE OF RESIDENCE

In 1970, a somewhat smaller proportion of older persons than of younger persons lived in metropolitan areas (64 versus 69 percent). Within the metropolitan areas, however, most (53 percent) older people lived in the central city while most (55 percent) of the under-65 lived in the suburbs.

VOTING

In the 1974 elections, older people were 14.8 percent of the voting age population (18+) but cast 17 percent of the votes. Some 51 percent of the older population voted, the highest proportion of all age groups except for the middle aged from 45 to 64.

MOBILITY

In the 4-year period ending March 1974, 17 percent or 3.5 million older persons moved from one residence to another. Ten percent moved within the same county, 3.5 percent moved to a different county in the same State, and only 3.3 percent moved across a State line. The extent of interstate movement seems larger because such migration tends to flow toward a very small number of States like Florida, Arizona, or Nevada.

EMPLOYMENT

In 1974, about 22 percent of 65+ men (1.9 million) and 8 percent of 65+ women (1.0 million) were in the labor force with concentrations in three low-earnings categories: part time, agriculture, and self-employment. Unemployment ratios were low due partly to the fact that discouraged older workers stop seeking jobs and are not counted as being in the labor market. For those remaining actively in the labor force and counted as unemployed, the average length of unemployment was greater than for younger workers.

AUTOMOBILE OWNERSHIP

As is true for most major household appliances, ownership of automobiles by older households is considerably below that of households with younger heads but a good part of the explanation rests with income level rather than age, health, or choice. A 1972 survey shows that the lowest proportion of households owning one or more cars was for those with 65+ heads (58 percent) and the highest was for those with 35–44 heads (88 percent). However, only among the households with under-$5,000 incomes was there a decrease in automobile ownership with advancing age. In the over $5,000 per year income households, there were practically no differences by age. Some 92 percent of elderly households with $15,000+ incomes owned at least one automobile.

PROJECTIONS TO 2000

New projections of the size of the population based on the population estimates for 1974, several new assumptions, and an ultimate completed cohort fertility rate of 2.1 (an ultimate level of 2.1 children per woman) show the following:

[Numbers in thousands]

Year	Total		Male, number	Female	
	Number	Percent of all ages		Number	Per 100 men
1980	24,523	11.0	9,914	14,609	147
1985	26,659	11.4	10,684	15,975	150
1990	28,933	11.8	11,518	17,415	151
1995	30,307	11.9	11,995	18,311	153
2000	30,600	11.6	12,041	18,558	154

94TH CONGRESS } SENATE { REPORT
1st Session } { No. 94-250

DEVELOPMENTS IN AGING: 1974 AND JANUARY-APRIL 1975

JUNE 24 (legislative day JUNE 6), 1975.—Ordered to be printed

Mr. CHURCH, from the Special Committee on Aging, submitted the following

REPORT

together with

MINORITY AND SUPPLEMENTAL VIEWS

[Pursuant to S. 267, 93d Cong.]

CHAPTER I

THE ADMINISTRATION STRATEGY FOR CUTBACKS IN AGING

Quite often, annual reports issued by this committee tell of congressional actions on aging in the face of administration reluctance or counter-proposals.

Last year, for example, *Developments in Aging: 1973 and January–March 1974*, told of Nixon administration resistance to an 11 percent, 2-part increase in Social Security benefits (Chapter I, p. 8). It also described an Administration tax package which would have—in the view of Congress—helped very few low-income elderly (Chapter II, pp. 32–33). Other bipartisan congressional criticism was directed at an Administration proposal to raise medicare costs for elderly participants (Chapter III, pp. 40–41); Administration failure to take a leadership role in nursing home reform (Chapter IV); Administration opposition to congressional initiatives on housing for the elderly (Chapter V, pp. 82–91); and, on several other matters, what appeared to be negative attitudes toward specific proposals or programs.

Many similar points of conflict have arisen in the 12 months which have just passed.

NOTE: For details on legislation passed during 1973–74, see *Action on Aging Legislation in 93d Congress*; prepared by U.S. Senate Special Committee on Aging, February 1975.

It is argued from the Office of Management and Budget—as well as from the White House and individual Federal agencies—that cutbacks in existing programs, or freezes against new ones, are essential during troubled economic times.

Members of Congress have argued, however, that good judgment and compassion must be built into all budget-making and budget-cutting decisions.

They also see an unfortunate trend in the making. As is so often charged in both Houses of the Congress, "The Administration is attempting to balance the budget on the backs of the elderly."

What follows in this chapter is a summary of Administration-Congressional disagreement in a few key areas in order to document what must be regarded as a hardening of Administration attitudes on matters of vital importance to older Americans.

Later chapters will deal with other issues in greater detail.

I. THE SOCIAL SECURITY PICTURE

Nearly every American has a very direct and important stake in the Social Security system.

More than 90 percent of all persons 65 or older are now eligible for monthly benefits. Approximately 100 million workers contribute to Social Security. In return, they build credits toward future benefits for themselves and their families.

To a very large degree, the Social Security system is a compact between the people of the United States and their Government. The Federal Government stands in the position of a trustee for those who have built up rights during their working years.

Social Security is also vastly different from the general revenue operations of the Federal Government. The cash benefits program,[1] for example, is almost entirely self-financing—paid for by earmarked contributions from employees, employers, and self-employed persons. These contributions are placed in separate trust funds and can be used for only two purposes: payment of benefits and the administrative expenses.

These points were further underscored when the Congress enacted an automatic adjustment mechanism [2] to make Social Security inflation-proof and to protect the elderly from the uncertainties of the political process. This automatic escalator provision was initially scheduled to apply to checks delivered in February 1975. But, it will now come into operation for checks received in July 1975 under recent amendments [3] to the Social Security Act.

These factors have all provided powerful reasons to discourage tampering with the automatic adjustment mechanism, or downgrading benefit outlays from the trust funds.

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[1] Old Age, Survivors, and Disability Insurance.

[2] Public Law 92-336, approved July 1, 1972.

[3] Public Law 93-233, approved Dec. 31, 1973. Public Law 93-233 provided a two-step, 11 percent Social Security increase as a downpayment on the cost-of-living adjustment for checks delivered in February 1975. The Act also changed the date for the automatic adjustment to July to permit the benefit rise to be payable in the same month that the Medicare Part B Supplemental Medicare Insurance premium charge is revised. This provision would make it possible to make both adjustments in benefit checks in the same month.

Nevertheless, the Administration apparently has launched a campaign to control so-called "uncontrollable" spending, and thus give the appearance of improving the overall fiscal picture under the unified budget. Former Office of Management and Budget Director, Roy Ash, was at the vanguard in this strategy.[4]

This rationale and earlier Administration pronouncements provided the basis for President Ford's proposal to place a 5 percent ceiling on the July 1975 Social Security cost-of-living increase, instead of the 8.7 percent projected rise.[5] When asked at a news conference whether his proposal would force the elderly "to assume an unfair burden of the hardship and sacrifices", President Ford gave this response:

> I think it is proper to indicate that I am not requesting Congress to keep the Social Security payments at the present level. I am saying that in order to have a total effort in this country, to combat inflation and to help the economy, that there should be a 5-percent increase, but no more.[6]

Several Members of Congress quickly opposed the Administration's proposal, which would have reduced Social Security benefits by more than $2.5 billion. Individuals would lose more than $80, on the average, than would be the case under the 8.7 percent increase.

AVERAGE MONTHLY SOCIAL SECURITY BENEFITS (DEC. 31, 1974)

Beneficiary	Present law rate	Present law rate increased by 5 percent	Present law rate increased by 8.7 percent [1]
Retired worker alone	$183	$193	$200
Retired couple, both receiving benefits	312	329	341
Aged widow	177	187	194

[1] Projected cost-of-living increase for checks received in July 1975 under the formula in Public Law 93-233.

Source: Social Security Administration.

Senator Frank Church, Chairman of the Senate Special Committee on Aging, gave this assessment:

> Once again, it illustrates the Ford administration's fundamental misunderstanding of social insurance programs, such as social security.
>
> And, this recommendation clearly shows a willingness on the part of the administration to change the rules of the game for the elderly after it has already begun.[7]

Additionally, Senators Church, Kennedy, Mondale, and Williams introduced S. Con. Res. 2 which expressed congressional opposition to legislation imposing a ceiling on the cost-of-living increase. All in all, 54 Senators sponsored this measure.[8] The strong bipartisan support generated for S. Con. Res. 2 virtually assures Social Security beneficiaries that they will receive the full amount of the cost-of-living adjustment, as authorized by law.[9] The resolution would also have the effect of nullifying the Administration's proposed 5 percent lid on increases in the Supplemental Security Income standards this July, since the SSI automatic escalator provision is pegged to the Social Security automatic adjustment mechanism.

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[4] For example, the lead paragraph in an article appearing in the January 26, 1975 edition of the *Baltimore Sun* said: "Concerned about what it fears is a national drift toward socialism, the Ford administration is mounting a major campaign to restrain the growth in Social Security benefits and other income-redistribution programs, Roy L. Ash, the budget director, said in an interview."

This same article also pointed out: "What the administration fears is that income-redistribution programs would push government spending to more than half the nation's gross national product if they continue to increase in years ahead at the same rate they have grown in the past.

"And if that happens, Mr. Ash said, the United States may be irreversibly on the road toward a fully controlled economy."

Baltimore Sun, "Ash fears socialism, urges limits on benefits," Jan. 26, 1975, p. A1.

[5] The actual cost-of-living increase will be 8 percent because the inflationary rate subsided in early 1975.

[6] *Washington Post*, Jan. 22, 1975, p. A12.

[7] *Congressional Record*, Jan. 21, 1975, p. S. 574.

II. THE MEDICARE PICTURE

Enactment of Medicare in 1965 was an historic victory for the Nation's elderly. But despite its valuable protection, Medicare's coverage has been whittled away by rising prices and administrative regulations.

The proportion of an aged's medical care expenses reimbursed by Medicare has fallen from 45.5 percent in fiscal 1969 to 38.1 percent in 1974. And the prospects are for further steep declines in the immediate future.

Deductible and other charges under Medicare have also risen sharply. The Part A Hospital Insurance deductible has jumped from $40 in 1966 to $92 in 1975, representing a 130 percent increase. This rise in out-of-pocket payments has produced spillover effects because coinsurance payments for hospitalization (for persons hospitalized from 6 to 150 days during a spell of illness) and extended care (for persons in nursing homes from 21 to 100 days) are based upon the Part A deductible amount.[10]

Premium charges for Supplementary Medical Insurance have more than doubled since 1966, increasing from $3 to $6.70 per month. On an annual basis for an elderly couple, Part B protection now costs $160.80. And, the Part B deductible has risen by 20 percent since Medicare became law, from $50 to $60.[11]

The net impact is that the elderly now pay more in out-of-pocket payments for medical care than the year before Medicare became law.

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[8] Sponsors of S. Con. Res. 2 include Senators Church, Kennedy, Mondale, Williams, Abourezk, Javits, Muskie, Leahy, Long, Roth, Bayh, Magnuson, Johnston, Brooke, McGee, Huddleston, Burdick, McIntyre, Bentsen, Cannon, Metcalf, Taft, Clark, Montoya, Ford, Moss, Stevenson, Cranston, Pastore, Tunney, Eagleton, Pell, Chiles, Eastland, Proxmire, Bumpers, Stone, Randolph, Hart (Michigan), Ribicoff, Hartke, Schweiker, Haskell, Stafford, Hatfield, Talmadge, Hathaway, Humphrey, Young, Inouye, Hart (Colorado), Jackson, Byrd (West Virginia), and McGovern.

[9] The House Budget Committee recommended in late March 1975 that a 7 percent ceiling be established for the July Social Security cost-of-living increase, as a means to reduce Federal outlays. Senator Church urged in a letter (sent on April 9) to the Senate Budget Committee that the House Budget Committee recommendation be rejected. Senator Church said: "A 7-percent ceiling would cut back benefits, on the average, by about $23 over the next year for persons who desperately need this money to buy food, medicines and other necessities. It would also run counter to the very purpose of the automatic escalator provision, which is to keep Social Security benefits in line with the rise in prices."

[10] A deductible charge in the initial payment that a beneficiary must pay before Medicare reimburses his or her hospital or medical services. The Part A Hospital Insurance deductible is now $92, and the Part B Supplementary Medical Insurance deductible is $60. In addition, Medicare patients must pay coinsurance charges after meeting the initial deductible payment. For example, a patient hospitalized from 61 to 90 days now pays a daily coinsurance charge of $23, or one-fourth of the Part A deductible. If a person must draw upon the lifetime reserve and is hospitalized from 91 to 150 days, the daily coinsurance charge is $46, or one-half of the Part A deductible.

[11] Social Security Amendments of 1972, Public Law 92–603, approved Oct. 30, 1972.

The aged's per capita direct payments amounted to $311 in fiscal 1973, or $74 more than the year preceding the effective date of Medicare.[12]

Yet, both the Nixon and Ford Administrations have proposed legislation to cut back Medicare coverage by saddling the elderly with new and potentially onerous costs. In part, these recommendations may assume that the elderly are now in a better financial position to absorb additional charges because of Social Security increases enacted into law since 1969. The most recent Administration pronouncement on this subject came this February in the fiscal 1976 budget message which called for enactment of legislation to modify Medicare's cost-sharing structure to provide: (1) A coinsurance charge under Part A equal to 10 percent of all charges above the deductible amount on all covered services (now the elderly pay a $92 deductible and nothing thereafter for covered hospital services until the 61st day of hospitalization); (2) an increase in the Part B deductible from $60 to $70, and rising thereafter in proportion to the percentage increase in Social Security benefits; (3) a 10 percent coinsurance charge on hospital-based physician services and home health services; and (4) a ceiling of $750 per benefit period for a patient's payments under Part A and a $750 limitation per calendar year for Part B. The Administration projected that these measures would reduce Medicare outlays by nearly $1.3 billion in fiscal 1976.

Almost identical recommendations were urged on November 26, 1974 when the administration presented its "Revised Fiscal Year 1975 Budget." The administration's proposal would have added nearly $425 million to the medical and hospital bills of the elderly and disabled during the present fiscal year. Senator Church objected, pointing out that the primary purposes was to create a misleading impression about the general budget picture. He said:

> If protection under the hospital insurance program were to be reduced—a proposition I strongly oppose—it would be only fair to reduce the contributions for the protection.
>
> Therefore, this is solely a maneuver to present a better general budget picture than in fact exists. What would happen if this proposal were to be adopted is that the excess collections from hospital insurance—excess because of the reduction in the protection furnished—would be borrowed by the Treasury for general purposes and bonds in a like amount issued to the hospital insurance trust fund. This is no way to "balance the budget."
>
> There is no deficit in hospital insurance financing. In fact, the program is overfinanced for many, many years into the future.[13]

III. THE FOOD STAMP PICTURE

Nearly 15 million persons participate in the Food Stamp program. Approximately 14 percent of the participants are 60 years of age or over, and about 10 percent are 65 or over.

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[12] Pages 13–14 of article cited in footnote 9.
[13] *Congressional Record,* Dec. 14, 1974, p. S. 21530.

As a part of a plan to trim the fiscal 1975 budgetary deficit and control inflation, the Administration proposed regulations on December 6 to cut back Food Stamp benefits. All Food Stamp households (except those not required to pay because they have little or no income) would pay 30 percent of their income to purchase Food Stamps (effective March 1, 1975) under the Administration's proposal. Approximately 95 percent of all recipients—or over 14 million persons—would pay more under the new plan.

	Household of 1—Price paid for $46 of stamps each month		Household of 2—Price paid for $84 of stamps each month	
Net monthly income	Current price	Price under new plan	Current price	Price under new plan
$25	$1	$7.50	$1	$7.50
$35	4	10.50	4	10.50
$45	6	13.50	7	13.50
$55	8	16.50	10	16.50
$65	10	19.50	12	19.50
$85	14	25.50	18	25.50
$105	18	31.50	23	31.50
$125	24	37.50	29	37.50
$145	30	43.50	35	43.50
$165 [1]	33	49.50	38	49.50
$185	36	55.50	44	55.50
$205			50	61.50
$225			56	67.50
$245			62	73.50
$265			64	79.50
$275			64	82.50

[1] All individuals with net monthly income of $154 and above would have to pay more for Food Stamps than they would receive, and would hence be removed from the program.

Source: Community Nutrition Institute.

At present, nearly all individual participants pay from 15 to 20 percent of their income for Food Stamps. And, most couples pay from 15 to 20 percent of their income for these coupons.[14]

Leading authorities—such as the Community Nutrition Institute—estimated that a very substantial percentage of elderly persons would drop out of the program under the Administration's plan because:

1. The Food Stamp benefit would be too small or perhaps disappear altogether.
2. Many recipients would not be able to afford the increased cost, especially as inflation intensifies.

One Department of Agriculture official informed the Community Nutrition Institute that conceivably one-half of all aged individuals and couples might be forced to leave the program because of the increased charges.[15]

The Congress responded promptly during the beginning of the 94th Congress by passing overwhelmingly legislation (H.R. 1589) to prohibit an increase in charges for Food Stamps for 1975.[16] President Ford announced on February 13, that he would allow the bill to become law without his signature.[17]

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[14] Community Nutrition Institute.

[15] For further information, see *C.N.I. Weekly Report*, Vol. 4, No. 49, Dec. 12, 1974, p. 1.

[16] The House of Representatives (by 374 to 39 on Feb. 4, 1975) and the Senate (by 76 to 8 on Feb. 5, 1975) passed H.R. 1589.

[17] *Washington Post*, Feb. 14, 1975, p. A1.

IV. CUTBACKS OR THREATS OF CUTBACKS ELSEWHERE

On other fronts the Administration launched a far-reaching attack to reduce Federal expenditures—both as a part of the revised fiscal 1975 budget and the new budget for F.Y. 1976.[18]

On January 30, 1975, President Ford submitted a rescission message, calling for proposed cutbacks in appropriations already made by the Congress for fiscal 1975.

Among the major rescissions for aging programs:

1. A $9 million cutback for the Title III State and Community Programs under the Older Americans Act, from the Congressional appropriation of $105 million to the Administration's budget request of $96 million.[19]
2. Elimination of funding for Title IV training. The Congress had previously approved $8 million in the Fiscal 1975 Labor-HEW Appropriations Act.
3. A $25.4 million reduction for the nutrition program for the elderly, from $125 million [20] to $99.6 million.
4. Impoundment of the entire Congressional $12 million appropriation [21] for the Older American Community Service Employment Act.
5. A reduction in the budgeted amount for the National Institute on Aging, from $15.74 million to $14.1 million.

Congressional approval is now required under the Congressional Budget and Impoundment Control Act [22] for all executive actions to withhold funds from programs. Now both the House and Senate must pass a rescission bill within 45 days of the President's proposed rescission; otherwise, the funds must be spent by the Administration.

The Congress did not, however, enact rescission legislation to, in effect, ratify the President's proposed impoundments. Thus, the Administration is obligating or preparing to obligate this money to carry out the intent of Congress, as expressed in appropriation bills.[23]

For the most part the fiscal 1976 budget funding requests are similar to the fiscal 1975 Administration requests. But for discretionary spending for aging programs, funding at the prior year's level would really be tantamount to a reduction because of the double-digit inflation which has driven up program and administrative costs.

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[18] For additional details, see, *The Proposed Fiscal 1976 Budget: What It Means for Older Americans*, Staff Report, Senate Special Committee on Aging, February 1975.

[19] Public Law 93–517, approved Dec. 7, 1974.

[20] Public Law 93–554, approved Dec. 27, 1974.

[21] Public Law cited in footnote 19.

[22] Public Law 93–344, approved July 12, 1974.

[23] The administration has released $9 million for the title III program under the Older Americans Act: $6 million for area planning and social services and $3 million for model projects ($1 million for improving legal representation for older Americans, $1 million for nursing home ombudsman activities, and $1 million for model projects of national scope). The Administration on Aging has sent out announcements to universities for the use of the $8 million for the title IV training program: $3.5 million is allocated for continuing 37 long-term training programs at 34 higher educational institutions; $3.5 million is set aside for the States for (a) development of courses related to aging at community colleges and (b) in-service training for improving staff capabilities at the State and local levels; and $1 million is allocated for the development of curriculum materials for training in gerontology. AoA has also released $25.4 million for the title VII nutrition program. The administration has released $15.74 million for the National Institute on Aging.

The new budget proposes a funding level for AoA programs that is identical to the fiscal 1975 request: $202.6 million. However, this estimate represents a $42.4 million cutback compared with the fiscal 1975 appropriation level. And, it would also constitute the largest dollar and percentage reduction in the entire history of the Older Americans Act. Nearly a $1.8 million reduction in funding is recommended in the new budget for ACTION's aging programs.

ACTION'S AGING PROGRAMS

[In millions of dollars]

	Authorization fiscal 1976	Budget request fiscal 1976	Appropriation fiscal 1975
RSVP	$20	$17.5	$15.98
Foster grandparents and senior companions	40	[1] 27.57	[2] 30.84
SCORE/ACE	([3])	.4	.4
Total		45.47	47.22

[1] $25,930,000 for foster grandparents and $1,640,000 for senior companions.
[2] $28, 280,000 for foster grandparents and $2,560,000 for senior companions.
[3] Open-ended authorization (such sums as are necessary).

For the third consecutive year the Administration has not requested any funding for Senior Opportunities and Services [24] or the Older American Community Service Employment Act. However, more than 1 million elderly persons are served under SOS. And, nearly 3,450 low-income persons in the 55-plus age category are employed under the Title IX senior community service employment program.

No additional lending authority is requested in the new budget for the section 202 housing for the elderly and handicapped program.[25] Yet, many older Americans find themselves in an impossible situation with regard to housing.

The Administration does, though, propose nearly a $500,000 increase for the National Institute on Aging, from the $15.74 million budget estimate for fiscal 1975 to $16.19 million. And, funding for enforcement activities under the Age Discrimination in Employment Act would be increased by almost $200,000 under the new budget, to nearly $2.2 million. This request would support 81 positions, the same number provided in fiscal 1975.

FINDINGS AND RECOMMENDATIONS

Recent recommendations by the Administration provide clear evidence that the Administration has given the elderly a low budgetary priority.

Such actions can only aggravate an already serious situation for persons struggling on limited incomes in a period of unacceptably high inflation.

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[24] Senior Opportunities and Services was established in 1967 to help assure that other Office of Economic Opportunity programs "serve, employ, and involve" the aged poor to the maximum feasible extent possible. SOS provides a wide range of services for the elderly poor, including home health, homemaker, home repair, consumer education, outreach and referral, transportation assistance, and many others.

[25] See Chapter VI, p. 69 for additional details.

In addition, the Administration has demonstrated a willingness to play fast and loose with the concept of contributory social insurance under Medicare and Social Security.

Administration proposals to cut back Medicare coverage and place a ceiling on Social Security cost-of-living increases underscore the importance of separating the transactions of the Social Security and Medicare programs from the unified budget.

For these reasons, the committee recommends that the Social Security Administration Act, S. 388,[26] be enacted into law expeditiously.

The committee further urges appropriate congressional actions to reverse shortsighted and ill-conceived Administration budgetary recommendations for fiscal year 1976.

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[26] In addition to separating the transactions of the Social Security trust funds from the unified budget, S. 388 would (1) establish the Social Security Security Administration as an autonomous agency outside the Department of Health, Education, and Welfare and place it under the direction of a three-member governing board appointed by the President with the advice and consent of the Senate and (2) prohibit the mailing of notices with Social Security checks which make any reference whatsoever to elected Federal officials.

CHAPTER II

IMMEDIATE AND LONG-RANGE DIRECTIONS IN SOCIAL SECURITY

Social Security will have a 40th anniversary in 1975.

It was on August 14, 1935, that President Roosevelt signed a bill launching the program.

In nearly four decades, what is now called the Old Age, Survivors, Disability, and Health Insurance Program (OASDHI), has been subject to frequent change and occasional criticism.

In late 1973 and in 1974, the criticism took a new turn. It was asked whether sharp inflationary increases in the cost of living would cause new and perhaps intolerable strains on the Social Security trust funds.

Some headlines asked whether the system was going broke.

Others quoted reports which seemed to indicate a severe plunge into deficit operation.

Congressional and other analyses indicate that inflation and readily foreseeable socio-economic trends will indeed cause a need for early and long-range corrective action.

But it is equally clear that there is time to make such changes, and that the more long-range predictions may be subject to major modifications.

The Senate Committee on Aging, at hearings on "Future Directions in Social Security," and in other studies, is assembling data and recommendations for change.

In the process, it is also attempting to keep a sharp focus on a paramount issue: the very real, day-in and day-out financial bind in which so many Social Security recipients now find themselves.

I. HOW ADEQUATE IS SOCIAL SECURITY?

Social Security increases in recent years have markedly improved the income position of older Americans. In 1974 nearly 30 million beneficiaries received a two-stage, 11 percent increase as a downpayment on a cost-of-living adjustment scheduled for 1975.[1]

This action—together with three other across-the-board raises since 1969—means that Social Security benefits have been boosted by 68.5

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[1] Public Law 93-233, approved December 31, 1974.

percent in a 5-year period.[2] These increases have been the major reason for the sharp reduction in poverty for persons in the 65-plus age category, from 4.8 million in 1969 to 3.4 million in 1973. In 1969 one out of every four older Americans lived in poverty as defined by the Census Bureau. By 1973 the ratio had fallen to one in six.

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[2] Four across-the-board Social Security increases have been enacted into law since 1969:

Date of enactment	Effective date	Percentage Amount
Dec. 30, 1969	January 1970	15
Mar. 17, 1971	January 1971	10
July 1, 1972	September 1972	20
Dec. 31, 1973	June 1974	11

Note: Individually, the increases total 56 percent. However, the raises aggregate 68.5 percent because of the compound effect of adding one on top of another.

PERSONS 65-YRS OLD AND OVER BY LOW-INCOME STATUS, FAMILY STATUS, AND RACE: 1973

[Numbers in thousands.—Persons as of March 1974]

Family status	All races				White				Black			
		Below low-income level				Below low-income level				Below low-income level		
	Total	Number	Percent of total	Percent distribution	Total	Number	Percent of total	Percent distribution	Total	Number	Percent of total	Percent distribution
Total	20, 602	3, 354	16. 3	100. 0	18, 754	2, 698	14. 4	100. 0	1, 672	620	37. 1	100. 0
In families	14, 310	1, 340	9. 4	40. 0	12, 993	988	7. 6	36. 6	1, 184	331	28. 0	53. 4
Unrelated individuals	6, 292	2, 014	32. 0	60. 0	5, 761	1, 711	29. 7	63. 4	489	289	59. 2	46. 6
Male	1, 442	391	27. 1	11. 7	1, 253	287	22. 9	10. 6	170	97	56. 8	15. 6
Female	4, 850	1, 624	33. 5	48. 4	4, 508	1, 423	31. 6	52. 7	319	193	60. 5	31. 1
Living alone	4, 495	1, 504	33. 4	44. 8	4, 198	1, 327	31. 5	49. 2	274	169	61. 8	27. 3

Source: Bureau of the Census.

WEIGHTED AVERAGE THRESHOLDS AT THE LOW-INCOME LEVEL IN 1973 BY SIZE OF FAMILY AND SEX OF HEAD, BY FARM-NONFARM RESIDENCE

Size of family unit	Total	Nonfarm			Farm		
		Total	Male head [1]	Female head [1]	Total	Male head [1]	Female head [1]
1 person (unrelated individual)	$2,239	$2,247	$2,350	$2,174	$1,887	$1,951	$1,832
Under 65 years	2,302	2,307	2,395	2,215	1,974	2,035	1,883
65 years and over	2,119	2,130	2,151	2,123	1,813	1,829	1,804
2 persons	2,874	2,895	2,904	2,847	2,434	2,439	2,346
Head under 65 years	2,967	2,984	2,999	2,908	2,543	2,546	2,455
Head 65 years and over	2,662	2,688	2,690	2,675	2,285	2,285	2,285

[1] For 1 person (i.e., unrelated individual), sex of the individual.

Source: Bureau of the Census.

Quite clearly, older Americans have made impressive gains economically on several fronts. But the elderly—who constituted the most economically disadvantaged age group in 1969—are still there today. The proportion of aged living in poverty (16.3 percent) is higher than for any other age group and is 47 percent above the level for all Americans (11.1 percent).

A. SOCIAL SECURITY LEVELS TODAY

Social Security is the economic mainstay for most older Americans. It accounts for more than half the income for two-thirds of individual beneficiaries and one-half of elderly couple beneficiaries. Social Security also represents almost the entire source of support—90 percent or more of total income—for 30 percent of single elderly beneficiaries and 15 percent of older couples.

Four across-the-board increases during the past 5 years have helped considerably in raising Social Security benefits to more adequate levels. On an individual basis, these raises have had the following impact:

MONTHLY SOCIAL SECURITY BENEFITS

[Rounded to nearest dollar]

	December 1969	December 1974
Maximum benefit, retired male worker alone	$161	$305
Maximum benefits, retired couple both receiving benefits	241	456
Average benefit, retired worker alone	97	183
Average benefits, retired couple both receiving benefits	169	312
Average benefit, aged widow	86	177
Minimum benefit, retired worker alone	55	94
Minimum benefits, retired couple both receiving benefits	83	141

Source: Social Security Administration.

But even with these advances, Social Security monthly payments still fall below the poverty thresholds for many older Americans. Quite often the disparity is very sharp. The average annual benefit for a retired worker ($2,196), for example, is $164 below the projected 1974 poverty benchmark ($2,360, see table below) for a single elderly person. In the case of the typical aged widow, her annual benefit in $236 under the poverty line.

	1974 annual benefit (rounded to nearest dollar)	Projected poverty threshold, single person aged 65 or older, 1974	Dollar difference: Social security benefit and 1974 poverty threshold
Average annual benefit, retired worker only	$2,196	$2,360	−$164
Average annual benefit, aged widow	2,124	2,360	−236

Source: Social Security Administration.

B. Comparison With BLS Intermediate Budget

Income adequacy was the number one priority of the 3,400 delegates at the 1971 White House Conference on Aging. Delegates at the Income Section, for example, recommended that the standard be in line with the BLS intermediate budget for a retired couple.[3] But this modest standard of living is beyond the means of nearly one-half of all aged-couples, and social security benefits are substantially below these projected levels of adequacy.

	1974 annual benefit (rounded to nearest dollar)	1974 BLS intermediate budget		Dollar difference: SS benefit and BLS budget
		Retired couple (estimated)	Single aged person (estimated)[1]	
Maximum benefits, retired male worker alone	$3,660		$4,791	$1,131
Average benefit, retired worker alone	2,196		4,791	2,595
Maximum benefits, retired couple both receiving benefits	5,472	$6,064		592
Average benefits, retired couple both receiving benefits	3,744	6,064		2,320

[1] The individual budget is estimated at 79 percent of the couple's budget.

Source: BLS.

II. IMPACT OF INFLATION UPON SOCIAL SECURITY BENEFICIARIES

Throughout 1973 and 1974 older Americans ran a losing race with inflation. From October 1972 (the month that the 20 percent Social Security increase was delivered), the consumer price index jumped by 23 percent (as of December 1974), an almost unprecedented advance. During this period Social Security benefits were boosted by only 11 percent in two stages, as a partial installment on the cost-of-living rise for July 1975. The forthcoming automatic adjustment, now projected at about 8.7 percent,[4] is based upon the increase in the consumer price index from the second quarter in 1974 to the first quarter in 1975.[5] This amount, plus the earlier 11 percent Social Security increase, will produce an aggregate raise of almost 21 percent (see footnote 2, page 11, for discussion of compound effect of Social Security increases).

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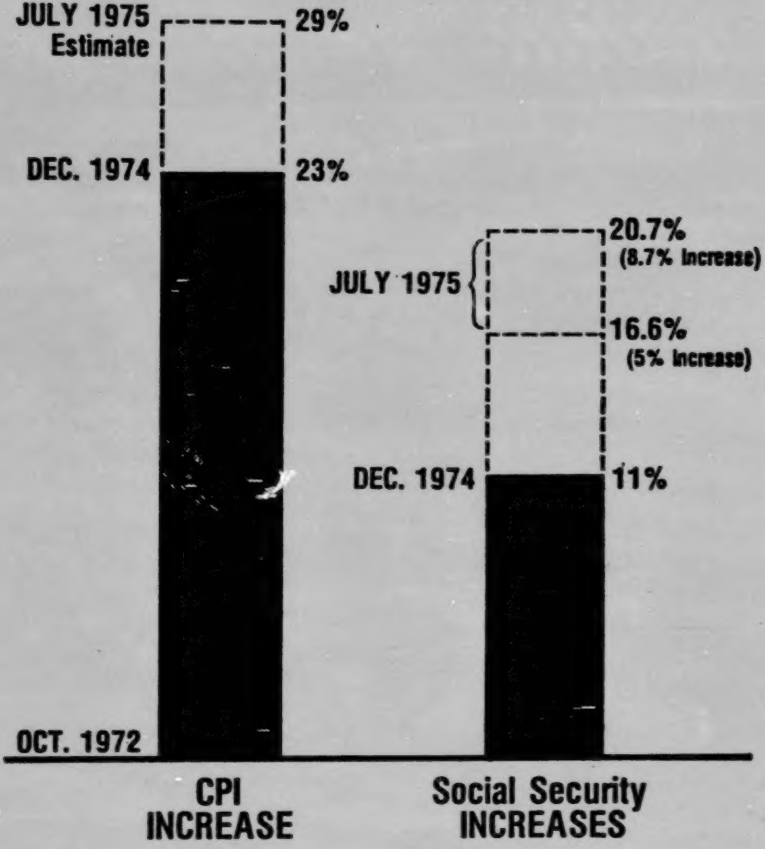
[3] The BLS Intermediate Budget provides a standard of measurement for a hypothetical couple in an urban area. The budget takes into account food, living arrangements, medical expenses, and other costs. The budget assumes that the couple is healthy and has an adequate inventory for furniture and household appliances. Practically all experts describe the BLS Intermediate Budget as a very modest standard of living.

[4] The actual cost-of-living increase will be 8 percent because the inflationary rate subsided in early 1975.

[5] Public Law cited in footnote 1.

However, this increase is still below the 23 percent rise in the overall cost-of-living from October 1972 to December 1974. And, if the inflationary rate continues at its present pace, the increase in the consumer price index will reach 29 percent by July 1975.

SOCIAL SECURITY INCREASES LAG FAR BEHIND PRICE RISES*



* Based on Consumer Price Index

Source: Bureau of Labor Statistics

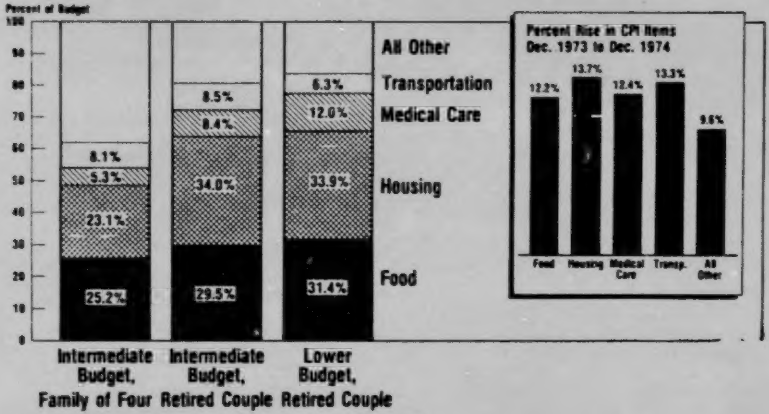
HEARINGS ON "FUTURE DIRECTIONS"

In mid-March 1975, the Senate Committee on Aging resumed its hearings on "Future Directions in Social Security." One major purpose was to determine the impact of inflation upon the elderly.

Much compelling testimony was received before, during and after the hearing. From December 1973 to December 1974 the Consumer Price Index rose by 12.2 percent, the most rampant increase in over a quarter of a century. Contrary to the 1973 experience (when the increase was largely concentrated in certain areas, such as food and fuel), the 1974 inflation was across-the-board.

But in the four areas where the elderly have their greatest expenditures—housing, food, medical care, and transportation– the rate of increases exceeded the rise in prices for all other items in the Consumer Price Index by 29 percent to 42 percent. These four items account for about 80 percent of the BLS Intermediate Budget for a Retired Couple.

Price Rises Are Especially Severe For the Elderly - - -
Items That Take Most of Their Budgets Are Rising at Faster Rates



Source: Bureau of Labor Statistics, U.S. Dept. of Labor, Autumn 1973.

Elderly persons throughout the Nation wrote the Committee and described in personal terms the effect of rising prices upon them. They also expressed resentment over President Ford's proposal to "freeze" the forthcoming increase at 5 percent. Among the examples:

From Tucson, Arizona:

> I am 85 years old. I paid income taxes 1920 to 1970—Social Security taxes 1937 to 1970. I have a home *paid for* which high taxes are about to take from under me. I had enough money saved for my last illness and burial. This eaten away by inflation. Very little income other than Social Security. What can be done for the millions like me—we also helped

build our wonderful economy. . . . The superstores are going wild since Feb. 1, increasing some 20 percent.

From Erie, Pa.:

Rents hereabouts, even the slummiest, are so high, by the time they are paid, ¾ths of one's income is *gone*. Soc. Sec. $92+S.S.I. (Supplementary Security Income) $93=$185 a month. That's my only & total income. (Oh, yes, $46 of food stamps for $36). (Then, they are going up, too) the rents . . . well, what isn't. Think suicide will solve all problems.

From Carnegie, Pennsylvania:

. . . the cost-of-living has been so high that any increase was gone before we got it . . . our pensions are so eroded that all we can do is buy the least expensive food we can find and wait each year to find out how much our rent was going up.

From Santa Rosa, California:

I am sure you will not be a party to ripping off the senior citizens by lowering the scheduled increase of 8.7 percent in Social Security. As a matter of fact, to compensate fully for the increase in living we should ask for an increase.

From Stoney Brook, New York:

I have worked all my life to support myself and my family (being a widow for 30 years) and have contributed to Social Security to make sure when I retire I will have adequate Social Security to live on.

Never collected unemployment.

Now I understand we are to get an 8.7 percent increase cost-of-living expense and instead we are told it will be five percent.

I am very bitter and disturbed . . .

We cannot maintain good health if we cannot buy food and necessities.

From Pittsburgh, Pennsylvania:

The Government should be ashamed at themselves fighting over what to do about Social Security. Trying to cut it down is like cutting our throats.

From Maywood, Illinois:

Inflation is stealing from my lifetime savings. Unless inflation is abated soon, I may be among those low-income senior citizens on relief during 1975–6. I believe Congress and the Senate should veto the President's proposed five percent limit in his S.S. program and enact their own law with payments to conform to the cost-of-living index, as means of arriving at living cost adjustments.

Inflation is expected to taper off in 1975. However, the overall rate is projected to be substantially above our historical experience and well above acceptable levels. Consequently, older Americans can expect little relief from the whipsaw effects of rising prices. (For further discussion of Committee hearings on "Future Directions in Social Security," see pp. 16 and 21).

III. ATTACKS ON SOCIAL SECURITY

Social Security came under attack on several fronts throughout 1974. Critics raised serious questions about the actuarial soundness and even questioned bedrock concepts. Part of the concern arose from reports about an increase in the actuarial deficit.

Estimates of the Situation

In June 1974 the annual report[6] of the Board of Trustees (the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare) disclosed a 2.98 percent long-range (over a 75-year period) actuarial deficit. Three major factors were cited by the Trustees:

1. A change in the demographic projections (primarily fertility assumptions) which accounts for about 76 percent of the increase in the actuarial deficit;
2. A higher estimated inflationary rate; and
3. An increase in the number of disabled-worker benefits being awarded.

The Board of Trustees declared:

> *Although the new population and fertility projections will have a major impact after the turn of the century on the long-range cost estimates, they will not have a significant effect in the short run.* (Emphasis added.) According to present short-range cost estimates, action to increase the combined income of the OASDI and hospital insurance systems for the next 5–10 years is not necessary right now. . . . The Board noted that one of the possible ways that the projected short-range excess of outgo over income in the cash benefit funds can be avoided is a reallocation of the total program income among the three funds (OASI, DI, and HI) by revising the contribution rates scheduled in present law without increasing the total rate.[7]

In February 1975 a special Panel on Social Security Financing submitted its report, based upon new data to the Senate Finance Committee concerning the actuarial condition of the cash benefits program.[8] The six-member panel projected a 6 percent long-range deficit. The advisory panel, which was appointed by the Senate Finance Committee, listed two reasons for projecting a larger deficit: a higher anticipated rate of inflation and a less rapid increase in birth rates from the present low level.

Certain critics of Social Security seized upon the projected long-range deficit to attack the program on several fronts. Many of the arguments had been raised previously and had been discredited. Nonetheless, they surfaced again.

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[6] House Document No. 93–313, "1974 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds," Letter from Board of Trustees Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, 93d Cong., 2d sess., June 3, 1974.

[7] Page 38 of House Document cited in footnote 6.

[8] "Report of the Panel on Social Security Financing" to the U.S. Senate Committee on Finance pursuant to S. Res. 350 (93d Cong.), 94th Cong., 1st sess., February 1975.

IV. RESPONSE TO ATTACKS ON SOCIAL SECURITY

On February 10, 1975, a bipartisan Ad Hoc Advisory Committee issued a comprehensive "white paper"[9] on Social Security. The paper concluded that the Social Security system is still sound and healthy,[10] despite the need for additional future financing. Signatories included five former Secretaries of Health, Education, and Welfare (Arthur S. Flemming, Robert H. Finch, Ellict L. Richardson, John W. Gardner, and Wilbur Cohen) and the three surviving former Commissioners of Social Security (Robert M. Ball, William L. Mitchell, and Charles I. Schottland).

The 4500-word statement called attacks on the system "a disservice to the nation."[11] The report said that such criticisms "have no more foundation now than they had when first made nearly forty years ago."[12]

Members of the Ad Hoc Committee emphasized, however, that several aspects of Social Security—such as benefit levels, treatment of women, and the adequacy and equity of financing—were proper subjects for continuing public debate and review.

> But discussion of that kind is very different from assertions that the system is basically unsound, that it is bankrupt, or for some other reason doomed to collapse, or that that it is a deception foisted on the American public.[13]

Additionally, the Ad Hoc Committee responded to specific attacks on the system. In response to the charge that Social Security is not a good financial proposition for the young worker, the white paper said:

> Statements have been broadly disseminated that social security gives the contributor a poor bargain, and that he could do far better by investing the amount of his contributions in the private markets. This is not true. If we exclude speculative investments (including investment in the erstwhile "ever-rising stock market"), which can always yield some individual a windfall but can also yield a terrible loss, the individual under the social security system receives better value from the government than he could obtain elsewhere. With the automatic escalation of workers' benefit rights as

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[9] "Social Security: A Sound and Durable Institution of Great Value." A reprint of this paper appears in the Feb. 20, 1975 *Congressional Record* at p. S. 2321. The full text also appears in *"Future Directions in Social Security Unresolved Issues: An Interim Staff Report,"* U.S. Senate Special Committee on Aging, 93d Cong., 2d sess., March 1975.

[10] A significant appraisal of the magnitude of public support for Social Security was provided by an analysis of findings from a Harris poll commissioned by the National Council on Aging. The NCOA reported: "An overwhelming 97 percent of the American people believe that Social Security payments to the elderly should automatically increase with rises in the cost of living. There is no indication that the public supports an arbitrary limitation on this increase." The full text of the NCOA summary appears as Appendix 2, p. 146 of this report. The Harris poll is described as the most extensive ever conducted to determine the public's attitude toward aging and their perceptions of what it is like to be old in this nation.

[11] Page 1 of paper cited in footnote 9.

[12] Page 1 of paper cited in footnote 9.

[13] Page 1 of paper cited in footnote 9.

> wages rise, and the automatic cost-of-living increase for those already on the benefit rolls, there is no question at all that the worker receives protection worth more than his total contributions with interest. This is true even if all or most of the employer contribution is assumed to rest on the employee in final incidence (either in the form of lower wages or in terms of higher prices to him as a consumer).[14]

Moreover, the white paper responded to other commonly raised assertions:

1. *Charge:* Social Security taxes are regressive because the wealthy pay smaller percentages of their earned income than do the poor.

Ad Hoc Committee response:

> This charge illustrates, indeed, the fallacy of looking at the two parts of social security in isolation from each other, an approach which inevitably distorts the issues and loads the argument. The issue here is not whether social security *taxes* are regressive but whether the social security *system*, *taking* into account both benefits and contributions, is open to this charge. The answer to that question is "no." The benefit formula is so designed as to give a larger return for each dollar of contributions to the low-wage earner than to the high. While there are other factors to be considered, some favoring the poor and some working against them, the net effect of the system is to transfer some income from the more affluent as a group to the less affluent.[15]

2. *Charge:* Social Security is not really a form of social insurance.

Ad Hoc Committee response:

> Social insurance is a concept long and well recognized across the world, and is one into which social security fits neatly. For good reasons, social insurance differs in important respects from private insurance, but it embodies the central elements of financial protection against defined hazards, through a pooling of contributions and a sharing of risks, with benefits payable as a matter of legal right on the happening of stated events. It is fallacious to argue, as some persons do, that the workers' payments are not insurance contributions because they are taxes—all taxes are compulsory contributions, either for the general support of government or for some particular governmental activity, and these payments are none-the-less contributions to an insurance system because they are also taxes. Congress used the word "insurance" in the statute as one indication of the character of the commitment it was undertaking, and the Supreme Court of the United States has stated that the term "social insurance" accurately describes the program.[16]

3. *Charge*: The Social Security trust funds are inadequate because they are invested in government bonds. Moreover, the size of the trust funds is grossly inadequate.

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[14] Page 5 of paper cited in footnote 9.
[15] Page 4 of paper cited in footnote 9.
[16] Page 3 of paper cited in footnote 9.

Ad Hoc Committee response:

> Charges that social security reserves have been grossly inadequate and charges that they are fictitious have been emphatically rejected by every one of the advisory councils, and they were rejected unanimously as early as 1945 by the social security committee of the insurance industry. A government insurance system which has its future income assured by the taxing power has no need to build up the huge funds that a private insurer would require if it underwrote similar liabilities, and indeed, it would be unwise to the point of irresponsibility to accumulate such sums. The only need for a trust fund is as a contingency reserve large enough to tide the system over any temporary change in income and outgo; if an increase in revenues should be necessary, the trust fund would enable Congress to delay such action during a period of economic recession. As for the worth of the assets in the funds, one need only consider that if a private trustee held these government bonds they would be gilt-edged securities, and then ask oneself how their value disappears when the same bonds are held by government officers as trustees.[17]

4. *Charge:* The Social Security retirement test (now requiring a reduction in benefits when annual earnings exceed $2,520 for persons under age 72) should be repealed.

Ad Hoc Committee response:

> Those who support the retirement test point out that its abolition would cost the equivalent of a one-half-of-1% increase in the combined employer-employee contribution rate and would benefit less than one-tenth of the people over 65 who are otherwise eligible for benefits. They ask whether funds in this amount are better used to supplement the incomes of those who still have substantial earning power or by spreading the funds among the nine-tenths who do not, or cannot, earn enough to bring them within the ambit of the retirement test.[18]

HEARINGS ON "FUTURE DIRECTIONS"

The Committee on Aging heard extensive testimony about the potential short-term and long-range financing problems confronting Social Security during the March hearings on "Future Directions in Social Security." Benefit payments are expected to exceed income in 1975, essentially for two reasons. First, the July cost-of-living adjustment will be considerably greater than initially projected because of the extraordinary increase in prices in 1974 and 1975. Second, the high rate of unemployment has caused a major reduction in the program's income.

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[17] Page 3 of paper cited in footnote 9.
[18] Page 8 of paper cited in footnote 9.

However, Social Security has a $46 billion trust fund to meet such temporary problems, until appropriate corrective action can be taken. Former Social Security Commissioner Robert Ball testified:

> This is why social security has the reserves it does. They should be drawn on in a period of recession like the present.

A sharp reduction in the projected birth rate is the principal reason for the long-range financing problem. If this trend continues there will be a substantially larger proportion of older persons to workers in the 21st century.

However, witnesses pointed out that other factors could offset this potential problem, assuming that existing projections prove to be accurate.

1. It is quite likely that a greater proportion of older persons will continue to work to more advanced ages, since there may be manpower shortages as well as less competition from younger workers.
2. With smaller families more women will probably enter and remain in the work force.

V. RECOMMENDATIONS FOR IMPROVING SOCIAL SECURITY

Major recommendations for improving Social Security were advanced by leading authorities throughout 1974 and in early 1975. On March 6, 1975, the 13-member Advisory Council on Social Security issued its report.[19]

An important recommendation would modify the method for computing benefit increases to reflect cost-of-living adjustments for workers.

As things stand now, whenever the consumer price index increases by at least 3 percent during a particular measurement period, benefits rise accordingly. The increase in benefits is accomplished, in effect, by raising the entire benefit schedule. This not only increases the benefits for all persons who are already retired, but it also increases the future benefits for those who are still working, because they will eventually obtain the advantages of the higher benefit schedule when they retire. At the same time, though, persons still working will also receive an increase in wages. This raises their average monthly earnings, resulting in an increase in their future benefits. The net effect is that benefit increases for persons still working are coupled with benefit raises for retired persons, producing the instability in the existing wage-replacement ratios.

To deal with this problem, the Advisory Council recommended a "decoupled" system. Specifically, the Council proposed that benefits for workers who will be future Social Security beneficiaries should be computed on the basis of a revised benefit formula using an index to adjust past earnings to take into account the average increase in earnings for all covered workers. As under present law, benefits for retirees should continue to increase as prices rise.

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[19] "Reports to the Advisory Council on Social Security," Washington 1975.

Among its other major findings and recommendations:

The Old Age, Survivors and Disability Insurance contribution rate should be gradually increased, and this increase should be met by reallocating contributions now scheduled in the law for Part A (Hospital Insurance) of Medicare. General revenues should be used to replace the income lost to the Hospital Insurance program under the proposed reallocation.[20]

The retirement test should be modified to provide a $1 reduction in benefits for each $3 of earnings between the exempt amount and twice that level (now $1 in benefits is withheld for each $2 of earnings above $2,520 for persons under age 72). Thereafter, benefits would be reduced by $1 for each $2 of wages above this 1-for-3 tier.

Requirements for entitlement to dependents' and survivors' benefits that are now applied to women should be applied to men. Benefits should be provided for fathers and divorced men as they are for mothers and women. The Act should be changed prospectively so that pensions based on one's work in noncovered Social Security employment will be subtracted from a person's Social Security dependents' benefits.

Further study is needed concerning the (1) effects of the Social Security program on different racial and ethnic groups, (2) ways of simplifying the administration of Social Security, and (3) the frequency of cost-of-living adjustments.

A general study should be made by a full-time nongovernmental unit regarding possible effects of Social Security on productivity, the proper size of the trust funds, the incidence of payroll taxes, and other basic questions.

Consideration should be given by Congress to raising the eligibility age for retirement benefits in the next century.

In February 1975 the AFL–CIO's executive council reaffirmed its support for Social Security and called criticism of the system's fiscal soundness as "distorted".[21] The Council also proposed that:

The maximum taxable wage be raised "over a period of years" [22] from $14,100 to $28,000.

Employers pay Social Security contributions on total payrolls, instead of just the maximum covered wage base.

General revenues be used to provide at least one-third of the program's costs.

The benefit formula be linked more closely to wages in the years nearing retirement, such as the highest 10 or 5 years of earnings.

An immediate cost-of-living increase be enacted.

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[20] The Administration expressed immediate opposition to the use of general revenues to finance Medicare. HEW Secretary Caspar W. Weinberger, for example, said on Mar. 7:

"The only recommendation of the Advisory Council I must oppose now is the one which calls for the introduction of substantial amounts of general revenue financing into the social security system. I think such a step would be inappropriate for a program whose strength has depended so heavily on support by working people and their employees. We should find other ways to solve the financing problems in social security."

[21] "Social Security System Needs More Taxes Due to Projected Deficit, AFL–CIO Says," *The Wall Street Journal*, Feb. 18, 1975, p. 5.

[22] Page 5 of article cited in footnote 21.

Future benefits be adjusted at least every six months whenever the consumer price index rises by 3 percent or more.

RECOMMENDATIONS MADE AT HEARINGS

The Committee's three days of hearings again sounded a strong vote of confidence for the Social Security system. Witnesses also urged several proposals to improve the financing of the program. Former Commissioner Robert Ball recommended that the maximum taxable wage base be increased in 1977 from the projected level of $16,500 to $24,000. With this change, it would be possible to reallocate the scheduled 0.2 percent increase in the Medicare contribution rate to the cash benefits program, without undermining the actuarial soundness of the Hospital Insurance program. Mr. Ball added:

> These changes in financing will have two effects: (1) The cash benefit trust funds will start to build up again and, under the most likely assumptions, the build-up will continue far into the 1980s or later. After these changes there would be no short-term financial problem for either the social security cash benefit program or the Medicare hospital insurance program. (2) The increase in the contribution and benefit base will increase the protection as well as the payments for the 15% of wage earners who are not now paying social security contributions on their full earnings. For example, a person earning at the maximum amount covered by social security and now age 55 would get, when he or she retired at 65, a benefit of over $100 a month above what he or she would get under present law. An individual earning the maximum amount and now 60 would get about $50 a month more than under present law when he or she retires at 65.

Mr. Nelson Cruikshank, President of the National Council of Senior Citizens, recommended a four-prong approach. In addition to incorporating the two elements of Mr. Ball's suggestions (see above), Mr. Cruikshank proposed:

1. Employers should pay contributions on total payrolls, instead of the maximum covered wage base.
2. There should be greater use of general revenues to finance Social Security.

VI. CONCERN ABOUT SSI

The Supplemental Security Income (SSI) program became effective in January 1974.[23] The program provides a guaranteed national income to those persons formerly assisted by State programs for the disabled, blind and aged. Administered by the Social Security Administration, SSI payments have been provided for those individuals transferred from the old welfare rolls, newly determined eligible individuals and so-called "essential persons", e.g., wives under 65 years of age who have spouses of eligible aged recipients who have themselves reached the age of 65. States have the option to supplement the Federal payment to a level equal to or greater than its former State assistance level. Thirty-nine States have opted to supplement the Federal payment and according to the Social Security Administration in all but three of these States, the average combined Federal and State payments are higher nationwide than those under the former assistance programs for the blind, disabled and aged.

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[23] Public Law 92-603 was signed into law on October 30, 1972.

SSI PAYMENTS: TOTAL ALL CATEGORIES, APRIL 1974[1]

	Total number of payments	Total Federal payments	Total State payments	Total Federal and State payments	Total SSI payment	Basic Federal payment	Total State payments
United States	3,242,766	$1,864,096	$244,216	$1,134,454	$367,578,822	$275,130,080	$92,448,733
Alabama	124,393	124,392		1	10,344,512	10,344,456	56
Alaska	2,578	2,578			266,727	266,727	
Arizona	22,869	22,869			2,271,916	2,271,916	
Arkansas	73,109	54,457	1,440	17,212	6,420,199	5,749,521	670,678
California	515,275	12,493	136,815	365,967	81,592,932	34,046,055	47,546,877
Colorado	35,683	35,683			3,036,797	3,036,797	
Connecticut	17,267	17,267			1,638,341	1,638,341	
Delaware	5,226	1,696	606	2,924	517,249	393,046	124,203
District of Columbia	14,308	10,332	431	3,545	1,644,407	1,537,002	107,405
Florida	104,166	91,331	1,188	11,647	11,499,378	10,416,001	1,083,377
Georgia	131,716	112,802	3,339	15,575	12,429,113	11,315,763	1,113,350
Hawaii	6,618	1,355	423	4,840	935,319	583,925	351,394
Idaho	6,423	6,423			545,504	545,504	
Illinois	124,475	80,850	4,232	39,393	13,450,914	11,799,112	1,651,802
Indiana	29,348	23,796	1,497	4,055	2,357,426	2,157,580	199,846
Iowa	18,402	15,525	280	2,597	1,563,409	1,420,419	142,990
Kansas	17,523	15,079	238	2,206	1,526,942	1,401,006	125,936
Kentucky	75,578	75,578			7,566,137	7,566,137	
Louisiana	130,705	91,135	4,462	35,108	12,741,812	11,098,665	1,643,147
Maine	19,668	10,208	2,578	6,882	1,878,658	1,392,174	486,484
Maryland	39,374	34,613	681	4,080	4,522,380	4,283,697	238,683
Massachusetts	94,037	306	26,520	67,211	12,823,817	5,446,310	7,377,507
Michigan	92,634	5,581	6,783	80,270	11,310,470	7,972,397	3,338,073
Minnesota	31,142	22,755	1,119	7,268	2,897,127	2,487,441	409,686
Mississippi	111,764	111,763			9,561,781	9,561,776	5
Missouri	95,950	95,950			7,937,006	7,937,006	
Montana	6,344	4,912	193	1,229	599,602	554,742	44,860
Nebraska	13,248	13,248			1,066,356	1,066,356	
Nevada	3,255	306	758	2,191	305,938	162,393	143,545
New Hampshire	4,031	4,031			284,218	284,218	
New Jersey	47,129	9,763	3,404	33,962	5,553,798	4,111,419	1,442,379
New Mexico	19,378	19,378			1,985,042	1,985,042	
New York	284,508	9,901	30,077	244,530	45,607,029	27,874,687	17,732,342
North Carolina	97,059	97,059			9,039,123	9,039,123	
North Dakota	5,915	5,915			504,856	504,856	
Ohio	97,684	87,870	1,812	8,002	9,936,848	9,472,240	464,608
Oklahoma	75,846	75,846			6,793,865	6,793,865	
Oregon	18,552	18,552			1,725,456	1,725,450	
Pennsylvania	98,037	6,179	2,021	89,837	10,790,730	9,406,378	1,384,352
Rhode Island	10,761	1,257	1,305	8,199	1,108,405	729,135	379,270
South Carolina	45,443	43,338	286	1,819	4,478,057	4,289,066	188,991
South Dakota	5,951	4,702	146	1,103	535,190	468,979	66,211
Tennessee	93,841	89,436	765	5,604	9,241,104	8,744,199	496,905
Texas	211,727	211,726		1	16,981,239	16,981,226	13
Utah	7,655	6,541	354	760	781,330	721,665	59,665
Vermont	6,098	6,098			533,085	533,085	
Virginia	37,337	37,337			3,522,311	3,522,311	
Washington	46,270	2,712	1,708	41,850	5,595,451	4,421,613	1,173,838
West Virginia	27,513	27,513			2,940,800	2,940,800	
Wisconsin	36,769	4,257	8,625	23,887	4,200,948	1,956,770	2,244,178
Wyoming	2,194	1,402	130	662	187,802	171,719	16,083

[1] Social Security Administration.

A. A YEAR OF LEGISLATIVE AND ADMINISTRATIVE CHANGES

The 93rd Congress passed several bills which amended the SSI law. Included were provisions to:

Increase the monthly income standards in two stages from $130 to $146 for an individual and from $195 to $219 for a couple;[24]

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[24] Public Law 93–233, enacted December 31, 1973.

Provide for automatic cost-of-living adjustments in the SSI system;[25]

Provide for an extension of food stamp eligibility for SSI recipients through June 30, 1975;[26]

Exempt the value of maintenance and support furnished by private, nonprofit retirement homes in determining eligibility for SSI.[27]

Although legislation assisted in several ways to improve the effectiveness of the program, SSI was still seriously affected by various problems and inadequacies, including lags in distribution of checks and emergency payments; delays in replacement of lost or stolen checks and effective and timely determinations of eligibility; and lengthy appeals procedures. Staff shortages caused and intensified such problems.[28] According to Social Security Commissioner James B. Cardwell, the error rate for persons not receiving checks or receiving incorrect checks was about 5 or 6 percent, caused chiefly by faulty data resulting from the conversion of State recipients' rolls and partly due to problems in Social Security's data system.[29] The Commissioner stressed that hours of overtime were being put forth to correct and overcome these administrative hurdles.

B. SSI's SHORTCOMINGS

Although described as a major step forward in assistance program philosophy, SSI is still a far cry from becoming what its original drafters intended it to be. Its major obvious flaw is failure to provide an income to eliminate poverty.[30] This criticism was expressed quite explicitly by David Mueller of the Idaho State Office on Aging during a Committee field hearing. Mr. Mueller said:

> The basic flaw of SSI lies in its ineffectiveness to provide purchasing power to the elderly consumer. Since the original legislation in 1972, inflation has eroded its intent.[31]

Senator Frank Church echoed this concern when he observed:

> To guarantee an income to needy individuals is superficial unless adjustments can be made to assure the individuals of sufficient assistance to combat inflation. I'm glad that the original levels of $130 and $195 have been increased to $146 and $219, but SSI still does not meet everyday needs.[32]

When Senator Church questioned Commissioner Cardwell about the cost of raising the income level to at least the poverty threshold, the Commissioner responded that it would:

> Increase the cost of the program in 1975, by over $3 billion . . . I am not optimistic frankly about our capacity to finance

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[25] Public Law 93-368, enacted August 7, 1974.

[26] Public Law 93-335, enacted July 8, 1974.

[27] Public Law 93-484, enacted October 26, 1974.

[28] In the Administration's budget request for fiscal year 1976, the Administration also made a supplemental request for fiscal year 1975 for $121 million for 11,500 new staffing positions for Social Security, with approximately 7,000 positions earmarked for the Bureau of SSI.

[29] Testimony before the Senate Committee on Aging, "Future Directions in Social Security," July 15, 1974.

[30] The current poverty threshold is estimated by the Bureau of Labor Statistics to be $2,490 for an individual and $3,210 for a couple (1974).

[31] Testimony before the Senate Committee on Aging, "Future Directions in Social Security," Twin Falls, Idaho, May 16, 1974.

[32] Opening Statement remarks during Senate Committee on Aging, "Future Directions in Social Security," July 15, 1974.

> it at this stage given the mounting pressure that is developing on the Federal budget, with the Federal budget being looked to again as one of the economic levers the Government has available to it as a fight against inflation generally. It's a very tough choice.

Senator Church responded by pointing out that the Congress is:

> Being asked to approve $100 billion for the military this coming year . . . I suppose it just comes down to what priority we can give how many people, and how much we care about abolishing poverty in this country.[33]

VII. HISTORIC ACTION ON PENSION PROTECTION

Congress acted in 1974 to protect pensions of approximately 35 million persons now participating in private employee benefit plans.

The historic bill, the Employee Retirement Income Security Act of 1974 (Public Law 93–406) was the product of 3 years of intensive action by the Senate Subcommittee on Labor, which conducted extensive research to make the case for pension reform. Senator Harrison A. Williams directed the pension study from its inception. The Senate Committee on Finance took part in intensive scrutiny of the need for the bill and its provision. Similar cooperative action took place in the House.

A special analysis of the bill, and a description of follow-up action taken since enactment, appears as Appendix 1, page 143, of this report.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Social security is the chief financial defense for workers and their families against loss of earnings because of death, retirement, or disability.

It should continue to remain the primary means of providing economic security against these three contingencies.

Some recent attacks on social security have been based upon misleading or inaccurate information. These accounts have only created needless apprehension and concern for social security beneficiaries and workers who are now contributing to this system, instead of making any meaningful contribution to the national dialogue concerning the future directions of social security.

Prompt action by appropriate congressional units, the administration, and the general public is needed to deal with social security financing issues. The Committee on Aging, however, wants to reemphasize that this problem is clearly solvable if approached in an intelligent and dispassionate fashion.

In this regard, the committee plans to devote special attention to recommendations for bringing the Social Security Trust Funds into actuarial balance. The committee is firmly committed to the principle that the social security program must be built upon sound actuarial, policy, and economic considerations.

It will also be vigilant in assuring that (1) the early warning signals of the board of trustees and the panel on social security

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[33] Colloquy between Commissioner James B. Cardwell and Senator Frank Church during Senate Committee on Aging, "Future Directions in Social Security," July 15, 1974.

financing are heeded, and (2) appropriate corrective action is taken to guarantee the integrity of the trust funds.

Additionally, the committee recommends that:

> Legislation should be enacted as soon as possible to: (1) reconstitute the Social Security Administration as an indedependent, nonpolitical agency outside the Department of Health, Education, and Welfare; (2) prohibit the mailing of political announcements with social security or SSI checks; and (3) separate the transactions of the social security trust funds from the unified budget.[34]
>
> The cost-of-living adjustment mechanism should also be made applicable for special minimum beneficiaries under the Social Security Act.[35]
>
> The retirement test under social security should be liberalized to allow older Americans to earn greater income.
>
> The income standards of the supplemental security income program should be raised to a level to abolish poverty for older Americans.
>
> Consideration should be given to provide cost-of-living adjustments more than once a year whenever the consumer price index rises by 3 percent or more, and to develop a special elderly index.

The committee's continuing study into "Future Directions in Social Security" will also seek to develop recommendations for (1) the special problems of minority groups, (2) equitable treatment for women and men under social security, (3) improvements in disability coverage, (4) coverage of persons with little or no work experience under social security, and (5) other crucial issues.

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[34] Senator Church introduced S. 388 (the Social Security Administration Act) on Jan. 27, 1975, to implement these three objectives.

[35] Senator Church introduced legislation (S. 650) on Feb. 11, 1975 to implement this recommendation.

CHAPTER III

MEDICARE AND PROPOSED NATIONAL HEALTH INSURANCE PLANS

In 1974 concern mounted about health problems confronting Americans of all age groups. National health insurance plans were considered by the Congress and seemed for a time to be close to enactment. Unfortunately, few of these plans took into adequate consideration the severe and growing needs of the elderly. In the same year, older persons were faced with increasing out-of-pocket costs as a precondition of their participation in Medicare, and Medicare paid less of the average health bill.

Important and essential services are still not covered, including out-of-hospital prescription drugs, eyeglasses, hearing aids, and dental care. Nursing home care and home health services, while technically covered under the law, still account for less than 3 percent of Medicare's $12.1 billion expenditure.

Subcommittee hearings during the last year exposed health problems for the aged that are far greater than commonly imagined. In short, large numbers of older Americans may be going without needed medical assistance for fear of what it might cost.

I. MEDICARE: WHAT'S COVERED AND WHAT ISN'T

Medicare is the Federal Government's largest expenditure in the area of health care, accounting for 43 percent of outlays.[1] Costs in 1974 were approximately $12.1 billion and are projected to reach $15.5 billion in 1976.[2]

Medicare has two parts: Part A, which pays for inpatient hospital care; and Part B, which pays for doctor's and other outpatient services.

All 65-plus Americans are eligible for Part A, Hospital Insurance; however, they are responsible for the first $92 of their hospital bill as a deductible.[3] If their stay exceeds 60 days, they must pay $23 a day for the next 30 days.[4]

Nursing home care is also authorized under Part A but only in very limited circumstances. Those who do qualify must pay $10.50 per day from their own pocket beginning with the 21st day. To be eligible for the nursing home benefit, a patient must qualify for what regulations describe as "skilled" nursing care. Post hospital home health care benefits are also authorized under Part A.

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[1] Special Analysis Budget of the United States Government, 1974, at p. 148.

[2] *The Proposed Fiscal 1976 Budget: What It Means for Older Americans,* staff report by the Special Committee on Aging, February 1975, at p. 8.

[3] On Jan. 1, 1974, the deductible rose to this amount from $84.

[4] On Jan. 21, 1974, this coinsurance was raised from $21.

To be eligible for coverage under Part B, each older person must sign up for the program and pay $6.70 per month ($80.40 per year),[5] In addition, each beneficiary must pay a deductible of the first $60 in doctor bills and outpatient services as well as 20 percent of all eligible services incurred after the deductible payment is satisfied. (See chart 1.)

CHART 1

MEDICAL CHARGES SOAR

	1966	1975	PERCENT INCREASE
HOSPITAL INSURANCE			
DEDUCTIBLE	$40	$92	130%
CO-INSURANCE			
HOSPITAL			
1st - 60th DAY	NONE	NONE	—
61st - 90th DAY	$10 DAILY	$23 DAILY	130%
LIFETIME RESERVE DAYS	$20	$46	130%
NURSING HOME/EXTENDED CARE			
1st - 20th DAY	NONE	NONE	—
21st - 100th DAY	$5 DAILY	$11.50 DAILY	130%
MEDICAL INSURANCE			
PREMIUM	$3.00	$6.70	123⅓%
DEDUCTIBLE	$50.00	$60.00	20%
CO-INSURANCE	20%	20%	—

Source: Social Security Administration.

Strong cost control regulations restrict what Medicare will pay the physician to a "reasonable" fee in light of prevailing charges in the area. Any charge in excess of this rate must be absorbed by the older person.

Part B provides a home health care benefit *without* prior hospitalization but with the same requirement under part A, namely the patient must require "skilled" nursing care.

SOME MAJOR OMISSIONS

Clearly, there are many gaps in Medicare's coverage of the health needs of the aged. First, and very significantly, preventive medical care is not authorized. For example, the cost of a yearly physical examination will not be reimbursed. In other words, Medicare only begins when health needs have reached a critical stage.

Numerous essential services are not covered at all (for example: eyeglasses, dental care, hearing aids, out-of-hospital prescription drugs, and care required by the chronically ill).

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[5] The premium increased from $6.30 to $6.70 per month in July 1974.

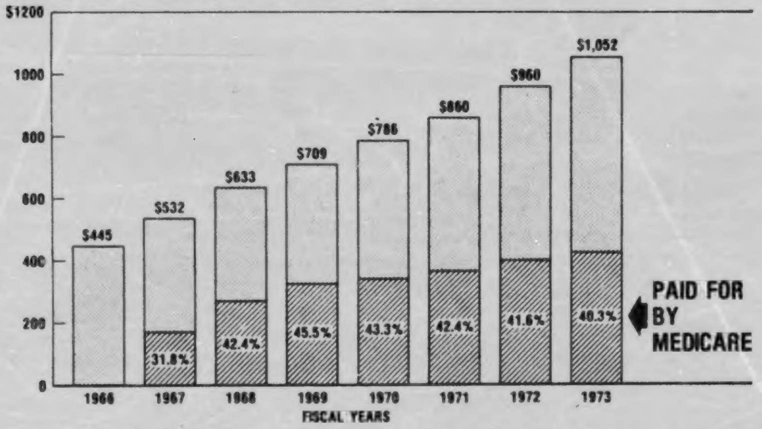
THE END RESULT: MORE COSTS AND FEWER BENEFITS

Today Medicare pays 38.1 percent of the health bill for the average older person.[6] This percentage is a drop since 1969 when Medicare paid about 46 percent of health care costs. While the elderly are receiving less, they have been paying more. For example, the Part A hospital deductible which began at $40 in 1966 has increased 130 percent to $92 today. Hospital co-insurance (beginning with the 61st day) has increased from $10 per day to $23 per day over the same period. Similarly, nursing home coinsurance beginning the 21st day also increased 110 percent from $5 to $11.50 per day. Under Part B, the insurance premium required to be eligible increased from $3 to $6.70 (a 123 percent jump).

In short, per capita out-of-pocket payments for medical care are today higher than they were before Medicare began. In Fiscal Year 1966, an older person on the average paid $237; by 1973, direct payments averaged $311, or $74 more than the year Medicare became law.[7] These facts have caused many elderly to view Medicare as a "broken promise".[8]

CHART 2

MEDICAL CARE BILL PER AGED PERSON AND PROPORTION COVERED BY MEDICARE, FY 1966 - 1973



Source: Social Security Administration

II. THE MINNEAPOLIS EXPERIENCE

Hearings by the Subcommittee on Health of the Elderly in July 1974,[9] documented that many elderly persons are, very simply, neglect-ing to accept any medical care whatsoever for fear of what it may cost—this despite the brave promises of Medicare.

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[6] Social Security Bulletin, May 1974.

[7] See source cited in footnote 6.

[8] Opening Statement of Senator Frank E. Moss, at hearing of Subcommittee on Health of the Elderly called "Barriers to Health Care for Older Americans," Part 10, Price, Utah, Apr. 20, 1974.

[9] Hearings cited in footnote 8, Parts 13 and 14.

Testimony at these hearings centered on an unusual clinic operated jointly by Abbott-Northwestern Hospital and the Minneapolis Age & Opportunity Center, Inc. (M.A.O.).

M.A.O., under the leadership of Executive Director Daphne H. Krause and a governing board of senior citizens, provides a broad range of services necessary to maintain the aged in their own homes and in independence.

In November of 1973, Abbott Hospital and M.A.O. opened a "free" clinic—free in the sense that older persons with low incomes ($4,500 for singles and $5,500 for couples) could receive medical and hospital services, with Medicare reimbursement accepted as full and final payment. In other words, the hospital agreed to absorb the costs of coinsurance and the deductibles, amounts usually paid out of the pockets of those eligible for Medicare.

Specifically, the Abbott-M.A.O. Clinic offered the following services without charge:

Health care in the outpatient clinic or in the hospital.

Free transportation to and from the clinic.

Counseling.

All necessary supportive services such as homemaker assistance, meals-on-wheels, legal advice, help with medical forms.

The first 3 pints of blood (not covered by Medicare).

In addition, prescription drugs are provided at cost to the hospital.

Response was overwhelming. In three months, more than 7,000 persons registered, and some 85 percent of these applicants were in need of immediate medical attention. The hospital did more EKG's (electrocardiograms) in a week than in the previous year. An unusual number of patients seen in the clinic required immediate hospitalization. On any given day about 40 clinic patients are hospitalized.

The number of elderly applying was not the only surprise. The patients turning up at the clinic's door were not the "traditional" poor who had experienced welfare programs and were probably eligible for Medicaid assistance. Instead, the applicants included former school teachers, lawyers, physicians, insurance company presidents, and school superintendents, all of whom had exhausted their resources and had done without the care they needed for fear of the expense—Medicare notwithstanding. For many of these people, who could qualify for Medicaid, that program was no answer. The pain and suffering of going without medical care was preferable to the indignity of applying for welfare assistance with the often added requirements of selling or putting a lien on one's home and spending down a small savings account to an even smaller level.

Lavetta Pearson, R.N., director, Abbott-Northwestern Hospital, Inc./M.A.O. Senior Citizens' Clinic, said:

> It has shocked my conscience and what ought to shock the conscience of all Americans is the fact that many of these senior citizens have not seen a doctor for periods ranging from 1 to as many as 50 years. Upon inquiry why they

> haven't seen or sought any medical attention, the answer invariably is they did not have the money, or they did not know whom to go to or how to get to the doctor's office. As one senior citizen clearly stated to me, if you only have a limited amount of income and you have to choose between buying pills and food, you are always going to buy the food.

The Clinic has been hard pressed to find enough doctors (especially primary care general practitioners) to take care of the heavy load. Nor could anyone foresee the pathology that appeared day after day. A random sample of a dozen patients disclosed the following problems:

A man admitted for heart surgery.

A woman with imminent gangrene of both feet.

A man suffering from rectal mass, anemia and rectal blood.

A woman who needed surgery to replace her left hip (she could not walk 100 yards without pain).

A man in need of stomach surgery.

A man with congestive heart failure, edema, cataracts, marked tooth decay, and dementia.

A woman with incontinence, urinary infection and severe arthritis.

A man whose last contact with a physician was his World War I physical.

A man who was blacking out because the batteries in his pacemaker needed replacement but who had put off having the batteries changed because he was still paying for the installation of the pacemaker three years earlier.

George Adamovich, Administrator of Abbott Northwestern Hospital stated:

> I emphasize that these patients are typical of many patients seen in our clinic—they suffer not only from severe medical problems, but a multiplicity of severe problems. More importantly, the patient has often held off seeking care in spite of noticeable, abnormal symptoms; and frequently the patient has not recognized unusual symptoms as potentially serious or even fatal.

Today—nearly eighteen months after the Clinic opened—some demand goes unmet. The shortage of primary care doctors has forced the Clinic to stop accepting new applicants. Older persons with severe pathologies continue to turn up and are accepted on an emergency basis at the rate of 25 to 30 per week. More than 4000 elderly patients await processing to become Clinic patients.

Important questions emerge from the M.A.O. experiment.

How much costly surgery or hospitalizations could be prevented if Medicare paid for some preventive medicine (such as a yearly physical)?

If more older persons could be maintained in the security of their own homes or apartments with a minimum of supportive services paid for under Medicare, how many hospital or nursing home admissions could be avoided?

And of course, with expanded coverage, how many elderly would be spared the agony of untreated illness and painful death?

The health care needs of many senior citizens can be alleviated if caught in time. Left untreated, the health problems of the elderly increase; many die and others are placed in nursing homes at two or three times the cost to the Government of in-home supportive services to maintain them in independence.

III. MENTAL HEALTH AND THE ELDERLY

In 1971 the Senate Committee on Aging issued its report, "Mental Health Care of the Elderly: Shortcomings in Public Policy," charging: "public policy in the mental health care of the aged is confused, riddled with contradictions and shortsighted limitations and is in need of intensive scrutiny geared to immediate and long-term action." [10]

In order to help fashion such a policy, the report recommended the establishment of a Presidential Commission on the Mental Health of the Elderly.

In May 1973, Senator Edmund S. Muskie, Chairman of the Subcommittee on Health of the Elderly, introduced a bill [11] to create such a Commission. Testifying in hearings on his bill last year, Senator Muskie stated:

> In the three years since this report was written, the lack of a firm policy with respect to the mental health care of the aged has become even more clear. As the American Psychological Association has stated, there are 3 million elderly who require mental health services, but a bare 20 percent of this number have their needs met through existing resources. Clearly, Medicare and Medicaid have failed to live up to their promise and responsibility with respect to the mentally ill elderly. . . . Recent Federal Court decisions attempting to define the rights of institutionalized patients are in conflict leaving many states in confusion. Finally, there is an alarming trend in the states to discharge patients from state hospitals into boarding homes and smaller community based facilities.[12]

Senator Muskie reported the results of a study by the Senate Committee on Aging [13] indicating a program underway in each state to discharge patients from mental institutions into nursing homes and boarding homes. He noted that there were 427,727 individuals in state hospitals in 1969, dropping 29 percent to 303,079 at the end of 1973. This trend is even more evident with respect to the elderly in state hospitals. Their numbers decreased by 40 percent during this same 4 year period (from 133,264 to 81,912).

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[10] *Mental Health Care and the Elderly: Shortcomings in Public Policy,* report by the Special Committee on Aging, Nov. 1971, Washington, D.C., at p. 3.

[11] See S. 1768, introduced on May 9, 1973. See page S. 8663 of the Congressional Record of that date.

[12] Statement by Senator Edmund S. Muskie before the Subcommittee on Health, Senate Committee on Labor and Public Welfare, May 1, 1974.

[13] See Supporting Paper Number 7, "The Role of Nursing Homes in Caring for Discharged Mental Patients," to be released.

The reasons for such transfers include:

First, humanitarian motives. The simple truth is that many elderly are in state hospitals not because they needed treatment but because they had no place else to go.

Second, recent court actions have played a part in fueling the discharge of patients in many states. An Alabama decision held that an individual committed to a state hospital for treatment had a constitutional right to such treatment, and those who received no treatment were required to be released.[14] Another decision in Washington, D.C., held that where a state derives any consequential economic benefit from the employment of patients, it must pay them the appropriate competitive wage.[15]

A third factor is economic expediency. The average daily charge in U.S. mental hospitals is about $800 per patient per month.[16] These same individuals can be housed in a nursing home for one half this amount or less.

A fourth, and most recent factor, is the enactment of the Supplementary Security Income program. SSI, as it is called, was enacted by the Congress in 1972 [17] in an effort to create a "minimum income floor" for payments received by certain welfare recipients. It is, in reality, a federalization of the adult assistance programs (aid to the aged, blind, and disabled), establishing a Federal floor of $146 for aged, blind, and disabled individuals and $219 for couples. SSI is 100 percent Federal money except in those States which had rates higher than $146 per month which are required to maintain recipients at their previous level.

The long and the short of the present situation is that the States can transfer individuals from state hospitals where they would be paying $800 in State money and place them in boarding homes at $146 per month in Federal money. The net benefit to the State treasury is about $1000 per patient per month, creating tremendous pressure for such transfers. In some parts of the nation, such as Long Beach in New York, a construction boom began and buildings opened hurriedly to receive discharged mental patients and their SSI checks.

Senator Muskie stated:

> Further analysis of this problem demonstrates significant dangers for the elderly:
>
> 1. Patients are being discharged wholesale and indiscriminately. There is virtually no screening to decide who are proper candidates for discharge.
> 2. There is no follow-up to determine if patients are properly placed in their new facilities.
> 3. Nursing homes, boarding homes, or shelter care facilities are ill-equipped to handle such patients. There are no psychiatric services available and no plan to rehabilitate patients.
> 4. There are few, if any, recreational services or activities.

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[14] *Wyatt v. Stickney*, 334 F. Supp. 1341.
[15] See statement cited in footnote 12.
[16] See source cited in footnote 13.
[17] Public Law 92–603.

5. There is a heavy, and perhaps unwise, use of drugs in nursing homes and other community-based facilities to offset the understaffing of facilities.

6. Many States give complete and final discharges to individuals, placing them together in certain areas of our cities which have become instant "geriatric or psychiatric ghettos." For example, 13,000 patients were discharged from Illinois State Hospital into an area called "Uptown" in Chicago, Illinois. In Washington, D.C., hundreds of patients will be found near Ontario Road N.W.[18]

THE BOARDING HOME CRISIS

No one knows with precision how many elderly have been placed into boarding homes (facilities offering meals and lodging) by the states. The evidence received by the Committee suggests that the number is large. In fact, it is likely that the majority of those removed from state hospitals in the past four years are in boarding homes today. SSI is clearly the principal reason for this transfer. There are other reasons, such as the increasing cost of health care and the absence of facilities which can meet state or Federal minimum standards. It is common for states to place welfare patients into such facilities as a way of getting around such standards. In this context, boarding homes are called "bootleg" nursing homes.

Of primary concern is the fact that few states either license or have any standards for boarding homes. Consequently, abominable conditions can exist in homes, and the lives of some patients are in jeopardy.

In April 1974 the Subcommittee on Health conducted hearings chaired by Senator Pete V. Domenici in Santa Fe, New Mexico.[19] New Mexico newspapers had disclosed poor conditions; poor food; negligence leading to death or injury; and physical punishment inflicted by operators upon their residents. Other examples of poor care discovered were: allowing patients to sit in their own urine, binding them to the toilet with sheets, and failure to cut toenails to the point where they curl up under the feet making walking impossible. A recurrent charge is profiteering, or cutting back on food, light, water, and heat to save money.

A staff report to Senator Domenici states "the above charges are valid but boarding homes in New Mexico, as bad as they are, are no worse than those visited in downtown Washington, D.C., or in Chicago, Illinois." [20]

In New Mexico, most residents of boarding homes are former mental patients. In fact, the number of aged in State mental hospitals dropped 54 percent between 1969 and 1973.[21]

Since the 1974 hearings, the State of New Mexico has acted to improve conditions. It is ironic that New Mexico was one of the few States to have enacted standards with respect to boarding homes. But these standards, promulgated in 1972, had never really been enforced.[22] The State health department was grossly understaffed with only 3 inspectors for more than 2,000 health care facilities.

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[18] See statement cited in footnote 12.

[19] Hearings cited in footnote 8, Part 12, Santa Fe, N. Mex., May 25, 1974.

[20] "Report on the New Mexico Boarding Home Association" prepared by Associate Counsel Val J. Halamandaris, Special Committee on Aging, for Senator Pete V. Domenici.

[21] See source cited in footnote 13.

PROPOSED SOLUTIONS

It is clear that other States need to enact laws regulating boarding homes which place appropriate emphasis on the care and safety of patients. A particular problem is protection of SSI, social security or other patient funds. In too many cases residents never see their allotments—the endorsement is an "X" on the back of the check sometimes signed by the operator himself. Clearly, some "screening procedures" need to be established to determine who are proper candidates from State hospitals and to provide appropriate follow-up care. Senator Pete Domenici has introduced legislation to allow payment of funds to care for the mentally impaired in a home health setting. See S. 1496, introduced Apr. 21, 1975.

In order to deal with deeper and more complex problems, Senator Muskie asked for the enactment of his bill creating the Presidential Commission on Mental Health and the Elderly.[23] The House and Senate Conferees agreed that it should be a Committee (not a Commission) on Mental Health and Illness of the Elderly, appointed by the Secretary of Health, Education and Welfare to study the future needs for mental health facilities, manpower, research, and training; to analyze and recommend the appropriate care for elderly persons who are in mental institutions, or who have been discharged from such institutions. The 9-member board would have one year to complete its work.

This proposal is presently incorporated in S. 66 which passed the Senate on April 10, 1975.[24]

IV. HOME HEALTH CARE

Home health care should provide a ready alternative to institutionalization, permitting appropriate recipients to remain living, at least somewhat independently, at home. Coordinated home care services should include visiting nurse, home aide, and laboratory services; physical therapy; drugs; and sick room equipment and supplies. They can prevent institutionalization or shorten the length of hospital stays, speed recovery, and bridge the gap in community health services for patients who are unable to visit a physician's office but do not need hospital care.

Earlier in this chapter it was pointed out that home health benefits are severely restricted under Medicare. Eligibility under both Parts A and B require that the beneficiary need part-time "skilled" nursing care.

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[22] See *Albuquerque Tribune*, May 13, 1974, by Laurie McCord, reprinted in "Barriers to Health Care," Part 11, p. 1113. See also testimony of Robert J. McCarthy, Ph.D., Clinical Psychologist, Assistant Professor, University of New Mexico, at p. 1076: "In general, I would agree with Ms. McCord's reporting on boarding homes in this month's Albuquerque Tribune which I understand is to be included as part of the Committee testimony." Senator Pete Domenici said: "We all know there is a problem. The State of New Mexico recognizes that problem. We are not here to criticize, we are here to help. We hope our hearings will contribute to some rethinking of current attitudes," p. 1056.

[23] S. 1768, see footnote 11.

[24] This bill is now under consideration by the House.

Other regulations limit the expansion of this program: Parts A and B have a maximum of 100 visits, and under Part A the recipient must have been previously hospitalized.

In Fiscal Year 1973, Medicare paid out $75 million in home health benefits, down from $115 million in Fiscal Year 1970.[25] Moreover, this $75 million figure accounts for less than 1 percent of the total Medicare expenditures of $12.1 billion. Estimates for Fiscal Year 1976 suggest a spending level of $148 million for home health care out of a total budget predicted at $15 billion (still only 1 percent of the total).[26]

Home health services under Medicaid are also limited, but for different reasons. The services under Medicaid are not limited to those needing "skilled" care. In fact, skilled care, basic unskilled care, and even preventive care are authorized. Unfortunately, the Department of Health, Education and Welfare has failed to (1) clarify what services are eligible for reimbursement, (2) define these services for the States, and (3) insist on anything more than token compliance with the law.

HEW's office of Social and Rehabilitation Service (SRS) conducted a survey in 1972 of Medicaid home health services. SRS identified 15 States that limited home health services to skilled care only. Most States have not developed significant home health programs. In 1972, Medicaid home health expenditures totalled $24 million or less than 1 percent of the Medicaid $5 billion total. Only 113,372 recipients were served nationwide.[27]

At a hearing before this Committee's Subcommittee on Health of the Elderly on July 9, 1974, the General Accounting Office provided a long-awaited report of Medicare-Medicaid home health services.[28] After outlining the difficulties and restrictions on these programs, and after documenting the actual decrease in the provision of services (home visits under Medicare decreased by 42 percent from 1968 to 1971), the GAO concluded:

> We recommended that the Secretary of HEW (1) impress upon the States the potential of home health care as an alternative to institutional care, (2) clarify for the States the specific home health services covered under Medicaid, (3) encourage the States to establish reasonable payment rates for services provided by home health agencies, and (4) assist home health agencies in their efforts to increase the health field's awareness and support of home health as an alternative to institutional care.[29]

On March 12, 1974, Senator Moss introduced S. 1163, which was also sponsored by Congressman Ed Koch in the House of Representatives.[30] The bill seeks to broaden the scope of home health benefits provided under both Medicare and Medicaid.

In addition, S. 1161 would authorize an experimental program to provide care for elderly individuals in their own homes. The program would allow subsidies to the family for care of elderly individuals in their homes.

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[25] "Home Health Care Benefits Under Medicare and Medicaid," audit by the U.S. General Accounting Office, presented to the Subcommittee on Health of the Elderly, July 9, 1974 (reprinted therein).

[26] See source cited in footnote 2.

[27] "Numbers of Recipients and Amounts of Payments under Medicaid, 1972," U.S. Department of Health, Education and Welfare, Social and Rehabilitative Services, May 23, 1974. Tables 4 and 5.

[28] See report cited in footnote 24.

[29] Hearings cited in footnote 8, Part 15, Washington, D.C., at p. 1396.

[30] H.R. 4227, March 12, 1975.

OTHER LEGISLATIVE INITIATIVES

Congress has received other legislation intended to support the development, expansion and maintenance of home health agencies and expand the coverage of Medicare Parts A and B to include home health services. However, only one of these bills was acted upon by the appropriate Committees and incorporated into other legislation. Senator Frank Church's bill (S. 2690), which would provide for grants for the establishment and initial operation of home health agencies, was accepted as a provision of the Health Services Act of 1974 in a pared-down, one-year funding of $12 million for home health agencies. Also authorized was $3 million to make grants to public and nonprofit private entities to assist in training of professional and paraprofessional personnel to provide home health services. The Health Services Act was vetoed by the President, who argued that it represented a significant increase in the Administration's budget because it established new health related programs. In response to the President's veto, Senator Edward Kennedy reintroduced the Nurse Training and Health Revenue Sharing and Health Services Act of 1975 (S. 66) early in the 94th Congress. S. 66 included Senator Church's home health amendment in the same form and authorization it had in the earlier Health Services Act. S. 66 was passed by the Senate on April 10, 1975, by a convincing vote of 77 to 14.

NATIONAL HEALTH INSURANCE PROPOSALS

Essentially four proposals were under consideration in 1974, including S. 3, introduced by Senator Edward M. Kennedy; S. 2513 introduced by Senators Russell Long and Abraham Ribicoff; the Administration's proposal, S. 2970; and S. 3286, introduced by Congressman Wilbur Mills and Senator Kennedy. The Subcommittee on Health of the Elderly held hearings to evaluate these proposals and the degree to which they were responsive to the needs of the elderly.[31]

The major provisions of each of the above bills follows below. Only S. 3 has been reintroduced in the 94th Congress.

MAJOR POINTS OF S. 3 NATIONAL HEALTH SECURITY ACT

1. Medicare would be replaced by a health insurance program and Medicaid would become a supplementary program. Beginning in mid-1973, there would be provision for comprehensive health insurance coverage, including preventive and disease detection services; care and treatment of illness; and medical rehabilitation.

2. There would be no cutoff points; no coinsurance (requiring out-of-pocket payments as under Medicare); no deductibles (calling for additional payments by patients as Medicare does); and no waiting

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[31] Another major proposal was sponsored by Senator Abraham Ribicoff, S. 3154 in the last Congress. The bill was reintroduced on April 17, 1975.

See also analysis in "Developments in Aging: 1973 and January-March 1974," report by the Special Committee on Aging, May 13, 1974, Washington, D.C., at pp. 47–48, 165–68. See hearings cited in footnote 8, Parts 8–9, 13–16.

period. Coverage under the program would be automatic. There would be no "means test" (as under Medicaid).

3. Virtually all health services would be covered in full except there would be certain limitations for nursing home care, dental care, psychiatric care; and prescription drugs.

4. *Dental benefits.* The Health Security Board is authorized to extend the coverage for dental services (limited to children up to age 15 at the start) faster than the timetable specified in the legislation if adequate manpower is available. In addition, the Board is required, within seven years of the effective date of the legislation, to publish a timetable for phasing in the entire adult population.

5. *Health Maintenance Organizations.* The name "comprehensive health service organization" is changed to "health maintenance organization." HMO's will now be required to furnish or arrange for all covered services except mental and dental services.

6. *Professional Foundations.* Medical foundations are given the same expanded drug benefit previously available only in HMO's. That is, a full range of prescription drugs is now covered for all patients served through HMO's or foundations. The foundations are required to provide the same range of services as an HMO.

7. *Maintenance and Long-Term Care.* A new section gives the Health Security Board authority to make grants for pilot projects to test the feasibility of home maintenance care for chronically ill or disabled people. If experience under these projects proves that home maintenance services reduce the need for institutional care and can be administered in such a way as to control inappropriate or unnecessary utilization, the Health Security Board is authorized to recommend expansion of these services to the entire population.

MAJOR POINTS OF S. 2513: CATASTROPHIC HEALTH INSURANCE AND MEDICAL ASSISTANCE REFORM ACT

The legislation consists of two parts: (1) A Catastrophic Illness Insurance Program and (2) A Medical Assistance Plan for Low-Income People. The catastrophic proposal would cover the same kinds of services currently provided under parts A and B of Medicare except that there would be no upper limitations on hospital days or home health visits. All persons insured by Social Security, their spouses and dependents, and Social Security beneficiaries would be eligible for this protection. However, benefits would start only after an individual was hospitalized 60 days in one year or after family medical expenses of $2,000. After these conditions had been met, benefits would be payable as under Medicare which provides for coinsurance payments beyond 60 days of hospitalization and for all medical services. Coinsurance charges would be limited to $1,000 for all persons including Medicare beneficiaries.

The Medicare program would be continued, but with the addition of the limitation on coinsurance payments for prolonged illnesses. Moreover, the bill would provide for coverage of immunization and pap smears for Medical beneficiaries.

The Medical Assistance Plan for Low-Income People would replace the existing State-Federal Medicaid program. States would be left to provide uncovered services, such as eyeglasses, hearing aids, drugs and dental services with the Federal Government providing half the cost. For low-income older Americans, the bill would pay for part B Medicare premiums as well as Medicare coinsurance and deductible charges. In addition, it would provide them with all medically necessary hospital, skilled nursing facility and intermediate care facility services. Home health care would also be available without limitation.

Income limits for eligibility would be $2,400 for an individual and $3,600 for a couple. A copayment of $3 would be required on patient-initiated services, such as visits to a doctor's office, but copayments could not exceed $30 per individual or family during a year. Copayments would be based on the amount of a patient's income less $50 after an individual had been institutionalized for 60 days in a long-term care facility.

MAJOR POINTS OF S. 2970; COMPREHENSIVE HEALTH INSURANCE ACT OF 1974

This program would provide a system of health insurance for everyone under either an Employee Health Insurance Plan or an Assisted Health Insurance Plan. Medicare would be included in the latter but would retain most of its present administrative structure. Medicaid would be abolished except for a residual long-term care program. Benefits for everyone in the program would have to include a minimum benefit package defined in the program. Cost sharing for everyone would be related to income. The maximum payments for the first year for Medicare beneficiaries would be $750 plus premium payments.

Medicare Part A and B would be combined and there would be 20-percent coinsurance charges on all covered health services until the maximum charge is reached. The current Medicare home health benefit would be reduced from 200 to 100 visits. Extended post-hospital care would be limited to 100 days per year as compared to the present provision of 100 days per benefit period or "spell of illness".

Additions to benefits currently provided under Medicare include unlimited catastrophic coverage of hospital and medical bills after the maximum liability of $750 is met (reduced for low-income persons). Out-of-hospital prescription drugs would also be included but only after a $50 deductible requirement is met. Moreover, the patient would then be subject to coinsurance charges after paying the first $50 for qualifying prescriptions. CHIP would also substantially modify the mental health benefit under Medicare. Instead of 190 lifetime days in an inpatient hospital, CHIP would cover 30 full days or 60 partial days of hospitalization per year. On an outpatient basis, there could be 30 visits to a comprehensive community care center or not over 15 visits to a private practitioner, compared with the $250 limit per year for doctor visits under Medicare. CHIP would not cover lengthy stays in nursing homes or intermediate care facilities.

MAJOR POINTS OF S. 3286; THE COMPREHENSIVE NATIONAL HEALTH INSURANCE ACT OF 1974

Every American regardless of the source of his income would be protected from birth until old age by this contributory national health insurance system. Medicaid would be repealed and Medicare incorporated. Benefits are similar to the Administration's proposal (S. 2970 above). Hospital and physicians' services would be offered without day or dollar limitation. Home health visits (100 per year) and 100 days care in an extended care facility would be covered as would out-of-hospital prescription drugs. Preventive health services are provided. These and other provisions are subject to a $150 annual deductible and a 25 percent coinsurance. These deductibles and coinsurance amounts need not be paid at the time services are rendered but may be deferred. In the case of low income families, these amounts are reduced. There are catastrophic protections in the bill so that the full costs of health services would be paid after an individual had incurred annual health expenses of $1,000. These benefits would be financed by a 4 percent payroll tax with employers paying 3 percent and employees 1 percent. In sharp difference with the Administration version, the bill calls for the creation of an independent social security agency to administer the program and provides a series of long-term care benefits including extended care, home health, homemaker services, nutrition services, day care, foster home care and community mental health. The long-term care program is voluntary, and available to Medicare recipients who agree to pay an additional $6 monthly premium. The bill would require the Social Security Administration to certify state long-term care agencies which in turn will designate service areas in which non-profit community long-term care centers would coordinate or provide health benefits.

It is to be reemphasized that only S. 3 has been reintroduced in 1975. However, it is likely that others will be introduced later this year, perhaps with some changes. Key Committee chairmen have indicated their desire to enact national health insurance legislation this year or by 1976 at the latest. While representatives of national organizations on aging did not unanimously agree to endorse any one bill, there was a general consensus on a few important points as listed below.

1. Representatives of senior citizens organizations emphatically agreed as to the need for national health insurance coverage for all Americans.

2. They agreed that the health insurance program for the aged (Medicare) should be integrated into the national plan covering all ages.

3. Most spokesmen argued that the partial funding of such a program should come from general revenues rather than more regressive payroll taxes.

4. They agreed that none of the existing benefits under Medicare should be sacrificed to bring the costs of the total program down. They argued instead for the need to include items not covered, such as eyeglasses, dental care, hearing aids and out-of-hospital prescription drugs.

5. They were particularly concerned that whatever bill is adopted should expand home health services and comprehensive nursing home benefits to meet the medical and social needs of the frail elderly. They endorsed this aspect of S. 3286. However, they would provide the benefits without requiring the elderly to sign up for them or pay a $6

monthly premium. The American Association of Homes for the Aging testified concerning S. 3286's long-term care provisions:

> In our view [it is] the first proposal sponsored thus far which addresses itself in a serious way to the long-term care needs of our elderly population.[32]

6. Spokesmen also argued for reducing or eliminating the present co-insurance and deductibles which seniors must pay to participate in Medicare. As noted previously, these disincentives prevent thousands of elderly from seeking the care they need for the singular reason that they cannot afford them.

FINDINGS AND RECOMMENDATIONS

A National Health Insurance program should be enacted for the benefit of all Americans, incorporating an expanded Medicare program. New benefits for the elderly should include long-term care, expanded home health and social services, eyeglasses, dental care, out-of-hospital prescription drugs and an annual physical examination. Such benefits should be provided without additional premiums, coinsurance or deductibles. Partial funding for such a program should come from general revenues.

A national health insurance plan should look first to maintaining seniors in independence and in their own homes with in-home services, meals-on-wheels, transportation, counseling and homemaker services. When seniors are too ill to stay home, then comprehenive nursing home benefits should be available. The Minneapolis Age and Opportunity Center, Inc. provides an example of the kind of program which most benefits the elderly.

Other hospitals around the nation should follow the example of Abbott-Northwestern, utilizing unoccupied hospital beds in caring for the elderly who urgently need care but who cannot afford it. The Abbott-M.A.O. clinic proves that a hospital can provide such services (absorbing Medicare's coinsurance and deductibles) and still be financially sound.

The Congress and the administration should place greater importance on the mental health needs of older Americans. A newly created committee could be helpful in focusing attention on the problems. In the meantime, the Federal Government should stop the flood of elderly presently moving from State hospitals into nursing homes which are ill-prepared to care for them, or even worse, to boarding homes where there is often poor care and little service. At the very least, States should enact standards and unified minimum regulations for boarding homes as well as provisions to insure that the discharged elderly receive the care and services they need.

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[32] See hearings cited in footnote 8, Part 16, at pp. 1480–90.

CHAPTER IV

NURSING HOMES AT THE CROSSROADS: IMPETUS FOR REFORM

Events in 1974 brought a broadened public concern for problems of the one million frail elderly who inhabit the Nation's 23,000 nursing homes. The subcommittee began publication of its study on nursing home problems, entitled *Nursing Home Care in the United States: Failure in Public Policy.* Officials in the Department of Health, Education and Welfare exhibited new commitment to reform. Consumer and other organizations intensified pressures for change, as did newspapers and television stations. Confronted by criticism from every side, individual operators and their national associations reacted first in anger and denial but have suggested by more recent actions their recognition of the need for meeting today's challenges.

I. THE SUBCOMMITTEE'S REPORT

The Subcommittee's Report, *Nursing Home Care in the United States: Failure in Public Policy*, is largely based on 25 hearings and more than 3,000 pages of testimony taken by the Subcommittee on Long-Term Care from July 1969 through February 1975. To deal with the intricate circumstances and governmental actions associated with long-term care and with the sheer volume of the material assembled by the Subcommittee, an unusual format was adopted. An Introductory Report was issued in November, and it was to be followed by a series of 9 monthly Supporting Papers. The eleventh volume of the series will be set aside for the comments and reactions of the nursing home industry, national organizations and the executive branch. The twelfth and final volume will update earlier material, analyze replies and comments and contain the Subcommittee's final recommendations to the Congress.

MAJOR POINTS OF THE INTRODUCTORY REPORT

The Subcommittee's Introductory Report was released on November 19, 1974, at a press conference attended by Senator Frank E. Moss, Chairman of the Subcommittee on Long-Term Care, Senator Charles Percy, ranking minority members, and Senator Pete Domenici. The report is in six parts. The first two parts provide statistics documenting the growth of the nursing home industry, noting:

> Medicaid now pays about 50 percent of the Nation's more than $7.5 billion nursing home bill, and Medicare pays another 3 percent. Thus, more than $1 of every $2 in nursing home revenues is publicly financed.
>
> There are now more nursing home beds (1.2 million) in the United States today than general and surgical hospital beds (1 million).

> In 1972, for the first time, Medicaid expenditures for nursing home care exceeded payments for surgical and general hospitals: 34 percent as compared to 31 percent for hospitals.
>
> Medicaid is essential for growing numbers of elderly, particularly since Medicare nursing home benefits have dropped sharply since 1969. Average Social Security benefits for a retired couple now amounts to $310 a month compared to the average nursing home cost of $600. Medicaid (a welfare program) must be called upon to make up the difference.
>
> The growth of the industry has been impressive. Between 1960 and 1970, nursing home facilities increased by 140 percent, beds by 232 percent, patients by 210 percent, employees by 405 percent, and expenditures for care by 465 percent. Measured from 1960 through 1974, expenditures increased almost 1,400 percent.

The third section of the report analyzes Medicare and Medicaid, their adequacy in terms of meeting the needs of older Americans and the appropriateness of Federal minimum standards for nursing homes under these programs. The report states:

> Despite the sizable commitment in Federal funds, HEW has been reluctant to issue forthright standards to provide patients with minimum protection. Congress in 1972 mandated the merger of Medicare and Medicaid standards, with the retention of the highest standard in every case. However, HEW then watered down the prior standards. Most leading authorities concluded at subcommittee hearings that the new standards are so vague as to defy enforcement.

Part four carries this theme forward with respect to alternatives to institutionalization:

> Despite the heavy Federal commitment to long-term care, a coherent policy on goals and methods has yet to be shaped. Thousands of seniors go without the care they need. Others are in facilities inappropriate to their needs. Perhaps most unfortunate, institutionalization could have been postponed or prevented for thousands of current nursing home residents if viable home health care and supportive services existed. Although such alternative forms of care may be more desirable from the standpoint of elderly patients—as well as substantially less expensive—the Department of HEW has given only token support for such programs.

In 1973 Medicare paid $75 million for home health services or less than 1 percent of Medicare's $12.1 billion expenditures in that year. Moreover, while all states are required to provide home health services under Medicaid 1972 outlays came to only $24 million out of Medicaid's $5 billion total.

Part five of the report charges that nursing home standards are not enforced and that nursing home inspections are a "national farce." The report says:

> There is no direct Federal enforcement of these and previous Federal standards. Enforcement is left almost entirely to the States. A few do a good job, but most do not. In fact, the

enforcement system has been characterized as scandalous, ineffective, and, in some cases, almost nonexistent.

The report suggests several reasons for the failure of the present inspection and enforcement system:

1. Inspections are infrequent (many homes are not even inspected once a year).
2. Many states do not have adequate numbers of inspectors to do the job.
3. Advance notice of inspection is routinely given.
4. Inspections become bureaucratic rituals leading to the accumulation of a tidy pile of papers but not to action.
5. The recommendations of the inspectors are often ignored.
6. There is fragmentation of the responsibility for inspection along political and geographic lines.
7. Inspections focus on physical plant rather than patient care.
8. Political influence and interference keeps some homes open.
9. The Federal government relies totally on the states to conduct inspection and certify nursing homes for participation in the Federal Medicare and Medicaid programs.
10. Most states have few enforcement tools with which to discipline nursing homes other than the expensive and cumbersome procedures to close a facility.

A sixth part of the report analyzes President Nixon's 1971 nursing home reforms, charging that they "had only minimal effect" and that they "fall far short of a serious effort to regulate the industry." (A detailed analysis of the 1974–75 HEW initiatives follows later in this chapter, see p. 54.)

The report concludes:

> The victims of Federal policy failures have been Americans who are desperately in need of help. The average age of nursing home patients is 82; 95 percent are over 65 and 70 percent are over 70; only 10 percent are married; almost 50 percent have no direct relationship with a close relative. Most can expect to be in a nursing home over 2 years. And most will die in the nursing home. These patients generally have four or more chronic or crippling disabilities.

It notes that most national health insurance proposals largely ignore the long-term care needs of older Americans. It calls for the establishment of a national policy with respect to the infirm elderly and for broadening the scope of Medicare coverage to provide expanded home health and nursing home coverage.

MAJOR POINTS OF SUPPORTING PAPER NO. 1

"THE LITANY OF NURSING HOME ABUSES AND AN EXAMINATION OF THE ROOTS OF CONTROVERSY"

Supporting Paper No. 1 reveals that the following were the most important nursing home abuses:

Negligence leading to death and injury;
Unsanitary conditions;

Poor food or poor preparation;
Hazards to life or limb;
Lack of dental care, eye care or podiatry;
Misappropriation and theft;
Inadequate control of drugs;
Reprisals against those who complain;
Assault on human dignity; and
Profiteering and "cheating the system."

The inevitable conclusion is that such abuses are far from "isolated instances." They are widespread. Estimates of the number of substandard homes (that is, those in violation of one or more standards causing a life-threatening situation) vary from 30 to 80 percent. The subcommittee estimates at least 50 percent are substandard with one or more life-threatening conditions.

These problems have their roots in contemporary attitudes toward the aging and aged. As Senator Frank E. Moss, chairman of the Subcommittee on Long-Term Care, has said:

> It is hell to be old in this country. The pressures of living in the age of materialism have produced a youth cult in America. Most of us are afraid of getting old. This is because we have made old age in this country a wasteland. It is T. S. Eliot's rats walking on broken glass. It's the nowhere in between this life and the great beyond. It is being robbed of your eyesight, your mobility, and even your human dignity.

Such problems also have their roots in the attitudes of the elderly toward institutionalization. Nursing home placement often is a bitter confirmation of the fears of a lifetime. Seniors fear change and uncertainty; they fear poor care and abuses; loss of health and mobility; and loss of liberty and human dignity. They also fear exhausting their savings and "going on welfare." To the average older American, nursing homes have become almost synonymous with death and protracted suffering before death.

However, these arguments cannot be used to excuse nursing home owners or operators or to condone poor care. Those closest to the action rightly must bear the greatest portion of responsibility.

To deal with the litany of abuses, action must be taken immediately by the Congress and the executive to: (1) Develop a national policy with respect to long-term care; (2) provide financial incentives in favor of good care; (3) involve physicians in the care of nursing home patients; (4) provide for the training of nursing home personnel; (5) promulgate effective standards; and (6) enforce such standards.

MAJOR POINTS OF SUPPORTING PAPER NO. 2

"DRUGS IN NURSING HOMES: MISUSE, HIGH COSTS, AND KICKBACKS"

The Subcommittee's second supporting paper examines the flow of medications through the nation's nursing homes and makes the following points:

—The average nursing home patient takes from four to seven different drugs a day (many taken twice or three times daily). Each patient's drug bill comes to $300 a year as compared with $87 a year for senior citizens who are not institutionalized. In all, $300 million a year is spent for drugs, 10 percent of the Nation's total nursing home bill.

—Almost 40 percent of the drugs in nursing homes are central nervous system drugs, painkillers, sedatives, or tranquilizers.

—Tranquilizers themselves constitute almost 20 percent of total drugs—far and away the largest category of nursing home drugs.

—Drug distribution systems used by most nursing homes are inefficient and ineffective. An average home of 100 beds might have 850 different prescription bottles and 17,000 doses of medication on hand. Doctors are infrequent visitors to nursing homes. Nurses are few and overworked. All too often, the responsibility for administering medications falls to aides and orderlies with little experience or training.

—Not surprisingly, 20 to 40 percent of nursing home drugs are administered in error.

—Other serious consequences include: the theft and misuse of nursing home drugs; high incidence of adverse reactions; some disturbing evidence of drug addiction; and lack of adequate controls in the regulation of drug experimentation. But perhaps most disturbing is the ample evidence that nursing home patients are tranquilized to keep them quite and to make them easier to take care of. Tragically, recent research suggests that those most likely to be tranquilized may have the best chance for effective rehabilitation.

A second part of this paper documents the Subcommittee's findings of widespread kickbacks. A kickback is the practice whereby:

—. . . pharmacists are forced to pay a certain percentage of the price of nursing home prescription drugs back to the nursing home operator for the privilege of providing those services.

—The atmosphere for abuse is particularly inviting when reimbursement systems under Federal and State programs allow the nursing home to act as the "middle man" between the pharmacy (which supplies the drugs) and the source of payment (private patient, Medicare, or Medicaid).

The Subcommittee reported:

—Kickbacks can be in the form of cash, long-term credit arrangements, and gifts of trading stamps, color televisions, cars, boats, or prepaid vacations. Additionally, the pharmacist may be required to "rent" space in the nursing home, to furnish other supplies free of charge, or to place nursing home employees on his payroll.

—The average kickback is 25 percent of total prescription charges; over 60 percent of 4,400 pharmacists surveyed in California reported that they had either been approached for a kickback or had a positive belief that kickbacks were widespread; these same pharmacists projected $10 million in lost accounts for failure to agree to kickback proposals.

—In order to lower costs to meet kickback demands, pharmacists admitted numerous questionable, if not illegal, practices such as: billing welfare for nonexistent prescriptions, supplying outdated drugs or drugs of questionable value, billing for refills not dispensed, supplying generic drugs while billing for brand names, and supplying stolen drugs which they have purchased.

The report concludes with recommendations for reducing drug errors, over-tranquilization, adverse reaction, and for preventing kickbacks. Specifically, the Subcommittee strongly recommended that HEW announce regulations forthwith for Section 242 enacted by the Congress in 1972. This section makes offering or accepting a kickback a crime punishable by a $10,000 fine, a year in jail or both. The law has not yet been implemented and enforced.

MAJOR POINTS OF SUPPORTING PAPER NO. 3

"DOCTORS IN NURSING HOMES: THE SHUNNED RESPONSIBILITY"

Supporting Paper No. 3 concludes that physicians have shunned their responsibility for the care of nursing home patients. Except for a small minority, doctors are infrequent visitors to nursing homes. The report says that doctors avoid nursing homes for many reasons:

—There is a general shortage of physicians in the United States, estimates vary from 20,000 to 50,000.

—Increasing specialization has left smaller numbers of general practitioners, the physicians most likely to care for nursing home patients.

—Most U.S. medical schools do not emphasize geriatrics to any significant degree in their curricula. This is contrasted with Europe and Scandinavia where geriatrics has developed as a specialty.

—Current regulations for the 16,000 facilities participating in Medicare or Medicaid require comparatively infrequent visits by physicians. The some 7,200 long-term care facilities not participating in these programs have virtually no requirements.

—Medicare and Medicaid regulations constitute a disincentive to physician visits; rules constantly change, pay for nursing home visits is comparatively low, and both programs are bogged down in redtape and endless forms which must be completed.

—Doctors claim that they get too depressed in nursing homes, that nursing homes are unpleasant places to visit, that they are reminded of their own mortality.

—Physicians complain that there are few trained personnel in nursing homes that they can count on to carry out their orders.

—Physicans claim they prefer to spend their limited time tending to the younger members of society; they assert there is little they can do for the infirm elderly. Geriatricians ridicule this premise. Others have described this attitude as the "Marcus Welby syndrome."

The report adds that the absence of the physician from the nursing home setting means placing a heavy burden on the nurses, who are asked to perform many diagnostic and therapeutic activities for which they have little training. But there are few registered nurses

(65,235) in the Nation's 23,000 nursing homes. These nurses are increasingly tied up with administrative duties such as ordering supplies and filling out Medicare and Medicaid forms. The end result is that unlicensed aids and orderlies with little or no training provide 80 to 90 percent of the care in nursing homes.

The report concludes that the physician's absence results in poor medical care and to some degree, in poor nursing care. Poor care has many dimensions, it means:

—No visits, infrequent, or perfunctory visits.

—The telephone has become a more important medical instrument in nursing homes than the stethoscope.

—No physical examinations, proforma or infrequent examinations.

—Some patients receive insulin with no diagnois of diabetes.

—Significant numbers of patients receive digitalis who have no diagnosis of heart disease.

—Large numbers of patients taking heart medication or drugs which might dangerously lower the blood pressure, do not receive blood pressure readings even once a year.

—Some 20 to 50 percent of the medications in U.S. nursing homes are given in error.

—Less than 1 percent of all infectious diseases in the United States are reported—a special problem in nursing homes where patients have advanced age and lessened resistance. This fact was graphically proven in 1970 when 36 patients died in a Salmonella epidemic in a Baltimore, Md. nursing home.

—Physicians do not view the bodies of patients who have died in nursing homse before signing death certificates.

The report offers recommendations designed to promote interest in geriatrics among the present and future generations of physicians with the belief that absent greater physician interest the litany of nursing home abuses will continue.

Major Points of Supporting Paper No. 4

"NURSES IN NURSING HOMES: THE HEAVY BURDEN (THE RELIANCE ON UNTRAINED AND UNLICENSED PERSONNEL)"

Supporting Paper No. 4 is entitled: *Nurses in Nursing Homes: The Heavy Burden.* The report examines reasons why there are so few nurses in today's nursing homes (56,235 for 23,000 nursing homes). It will report that the few nurses who do work in long-term care facilities are overworked and tied down with administrative duties. This means that 80–90 percent of the care is provided by untrained aides and orderlies sometimes hired literally off the street and paid the minimum wage. Most have less than a high school education, no training or prior experience and they(aides) show a turnover rate of 75 percent a year.

Major Points of Forthcoming Supporting Papers

Supporting Paper No. 5, *The Continuing Chronicle of Nursing Home Fires* examines the reasons for 4,800 nursing home fires in 1971 and why 60 to 70 percent of U.S. nursing homes continually have one or more major fire deficiencies.

Supporting Paper No. 6, *What can be Done in Nursing Homes: Positive Aspects in Long-Term Care* will make the case that it is unjust to condemn all nursing homes. There are many fine homes in America. This paper attempts to explain what makes them what they are.

Supporting Paper No. 7, *The Role of Nursing Homes in Caring for Discharged Mental Patients* will examine in detail the current trend to "dump" thousands of mental patients from state hospitals into nursing homes, and questions the ability of nursing homes to deal effectively with these patients.

Supporting Paper No. 8, *The Access of Minority Groups to Nursing Homes*, will ask why there are so few members of minority groups in nursing homes. It concludes that discrimination, social and cultural differences, cost, lack of information and individual choice all contribute to the present reality: only 4 percent of the 1 million nursing home patients are members of minority groups.

Supporting Paper No. 9, *Profits and the Nursing Home: Incentives in Favor of Poor Care*, examines the role of the profit motive, the adequacy of present nursing home reimbursement, the effect of reimbursement formulas and the general profitability of the nursing home industry. One finding: between 1969 and 1972 the 106 publicly traded nursing home chains had a 116 percent increase in average net income.

II. THE NEW YORK TIMES SERIES AND THE SUBCOMMITTEE'S NEW YORK HEARINGS

In October of 1974, the New York Times began a series of articles on nursing home problems, written by John Hess. The articles, grounded on extensive research, soon attracted attention to financial manipulations (to defraud the government) and to the poor care which inevitably resulted. The leads originated by Mr. Hess, as well as others, were pursued by Assemblyman Andrew J. Stein, Chairman of the New York Assembly's Temporary Committee to Investigate Living Costs and the Environment.[1]

The central figure in the New York probe soon became Dr. Bernard Bergman, a substantial shareholder in a publicly traded nursing home chain called Medic-Home Enterprises. Dr. Bergman was reputed to have additional nursing home holdings not only in New York but in other States as well. In December, the Office of the Welfare Inspector General of the State of New York to some degree estimated the number of "Bergman-related" homes in New York at about 55. This report also disclosed apparent irregularities in the books of the Towers Nursing Home in New York City which was owned by Dr. Bergman.

In an attempt to pursue these matters further, Assemblyman Stein directed subpoenas to some 25 nursing homes most with alleged ties to Bergman. Attorneys for these nursing homes challenged the Stein subpoenas in New York State court, charging that the Stein Commission lacked authority to investigate nursing homes. At this point,

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[1] See coverage in *Newsweek*, February 23, 1975, p. 23.

Senator Moss directed the Subcommittee staff to structure hearings in New York to be conducted by the Subcommittee on Long-Term Care. Some 40 subpoenas were issued by the Subcommittee to operators and vendors who had been under scrutiny by the Subcommittee including most of the facilities subpoenaed by the Stein Commission.

In his opening statement in the first New York hearing on January 21, 1975, Senator Moss spelled out the Subcommittee's legislative concerns indicating the direction and purpose of the hearings.

Senator Moss called New York's cost related reimbursement an "incentive to spend and spend because whatever is spent will be returned with a profit."

He added: "The system as it operates in New York would make defense contractors drool with envy. Since all states are required to adopt a cost related reimbursement formula by July 1976, it behooves us to take a good look at what you have here," he said.[2]

Other issues emphasized by Senator Moss:

—The adequacy of present ownership disclosure provisions which require anyone with a 10 percent interest or greater, to disclose his interest to the State.

—The adequacy of New York nursing home cost and financial disclosure law.

—The possibility of kickbacks between nursing homes and suppliers such as pharmacists, linen, food or contract cleaning vendors.

—The adequacy of present regulations protecting the mishandling of patient accounts or personal expense money by nursing home operators.

Testifying at this hearing, Assemblyman Stein and two staff assistants told the Subcommittee of the financial manipulations and poor care they had discovered through their investigations. A Stein Commission chart showed what was described as multiple real estate transactions involving the Willoughby Nursing Home for the asserted purposes of inflating Medicaid costs. Another display alleged that expenditures varied up to 400 percent for specific services such as housekeeping or laundry, implying extravagance of kickbacks. Another exhibit indicated that 22 out of 25 homes were "bankrupt," according to reports they submitted to the State Health Department. And yet investors continued to pay high amounts to purchase these homes.[3]

Dr. Jay Dobkin, Chief Medical Resident at Morrisania City Hospital, testified that a "nursing home case" had become a term in hospital jargon for dehydrated patients with bed sores brought in from nursing homes.[4] Anastasia Hopper former Chief of New York City Inspectors and Miss Irene Jarvis, R.N., former city inspector, testified from their experience as to the poor care in some New York Homes and described their frustrations when their recommendations for discipline were ignored.[5]

Dr. Bergman, testifying under oath, disputed charges made against him in the public press and by the Stein Commission. He asserted that he had an operating interest in only two nursing homes. He did acknowledge interest in the real estate of other New York homes. He denied that his homes offered poor care of that he had indulged in any financial manipulation for purposes of inflating Medicaid costs.

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[2] "Trends in Long-Term Care," part 23, hearings not yet in print.
[3] Hearings cited in footnote 2.
[4] Hearings cited in footnote 2.
[5] Hearings cited in footnote 2.

Following the lengthy Bergman statement, Senator Moss asked a few questions of Dr. Bergman, stating that more detailed questioning would come at a subsequent hearing after the staff and the U.S. General Accounting Office had a chance to evaluate Bergman records supplied that morning. February 4 was set as the date.

Just prior to adjournment Senator Moss allowed Special Counsel Gary Naftalus to ask a series of questions which related to Dr. Bergman's alleged attempts to seek political influence and favor. Dr. Bergman acknowledged that he had talked with Speaker of the Assembly Stanley Steingut and that he (Bergman) had met with Speaker Steingut and his Counsel, Daniel Chill, in Governor Nelson Rockefeller's office. Dr. Bergman denied Governor Rockefeller was present and denied that any influence was sought.[6]

Dr. Bergman failed to appear at the second hearing on February 4. His attorney argued that the initial subpoena did not carry over to the second meeting. Senator Moss conferred with Senators Charles Percy, Harrison Williams and Pete Domenici who were present and then stated that he would seek to hold Dr. Bergman in contempt. Samuel Dachowitz. Bergman Certified Public Accountant, who certified Bergman's net worth at $24 million in 1973, asserted his constitutional rights and did not testify. Speaker Steingut denied any wrong-doing on his part, testifying under oath that he had neither used his influence on behalf of Dr. Bergman nor sought to quash the Stein investigation.[7]

Meeting in Executive Session the full Senate Special Committee on Aging considered the pending contempt of Congress citation against Dr. Bergman. With 17 Senators present the Committee voted to hold the contempt citation in abeyance issuing the full Committee's subpoena commanding Dr. Bergman's appearance in Washington on February 19. Dr. Bergman did appear at the hearing but asserted his constitutional rights against self incrimination.[8]

III. INVESTIGATIONS AND STUDIES NOW UNDERWAY

Governor Edward Carey of New York appointed a Special Prosecutor, Joseph Hines, to investigate possible criminal violations. He also appointed a blue ribbon Commission under New York's Moreland Act and named famed attorney Morris B. Abram to head it. Both panels continue their investigations. But the publicity of the New York nursing home investigations had a ripple effect into other states on the East Coast and eventually to all parts of the U.S. Undoubtedly, the Subcommittee's reports have also spurred these investigations:[9]

In California an investigation is underway after a nursing home operator charged under oath that elderly alcoholics are being held prisoner by some facilities in order to collect the patients' Medicaid or Social Security checks.

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[6] See coverage in *New York Times*, Jan. 22, 1975, pp. A1 and 41.

[7] See *New York Times*, Feb. 5, 1975, p. A1 ; "Trends in Long Term Care," part 24.

[8] "Trends in Long-Term Care," part 25.

[5] Hearings cited in footnote 2.

In New Jersey, one owner has been indicted, grand juries and a Committee of the State Legislature are investigating, as well as the State Investigation Commission.

In Texas, a state legislator has released a report citing numerous "atrocities" alleged to exist in nursing homes.

In Illinois, State and Federal investigators have joined forces to investigate allegations of "massive fraud".

In Connecticut, the General Assembly has formed a special Committee to investigate nursing homes.

Other States with investigations underway include Kansas, Wisconsin, Minnesota, Florida, Maryland, Virginia.

With the help of the U.S. General Accounting Office the Subcommittee is studying material it received under its subpoena power and will issue a report later this year. Additional hearings are planned and some 48 bills have been introduced by Senator Moss.

IV. INITIATIVES BY THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The Department of Health, Education, and Welfare is charged with implementation and enforcement of Federal minimum standards for nursing homes under the Medicare and Medicaid program. As noted in the Subcommittee's Introductory Report, the Department was given very poor performance ratings through 1973 by experts polled by the Subcommittee on Long-Term Care. Some 86 percent of the experts stated that President Nixon's nursing home "initiative" did not reach the major problems in the field on long-term care; 80 percent indicated that the quality of care had been improved only to a minor degree or not at all by the Nixon "reforms".[10]

Action by the Department in 1974 started on this same critical note when HEW promulgated final unified regulations for Medicaid and Medicare Skilled Nursing Facilities in the January 17, 1974 *Federal Register.* There regulations were for the most part the interim regulations proposed in July 1973, which occasioned hearings by the Subcommittee on Long-Term Care and sharp protest by consumer representatives and representatives of senior citizens organizations. The Subcommittee's Introductory Report characterizes these standards as weak, vague and misleading with virtually all of the specifics deleted in the name of "flexibility". HEW replied that the changes amounted only to removing "excess verbiage". Senator Moss reacted calling the standards "so vague as to defy enforcement, he said that "without the addition of these specifics, the proposed regulations represent an unconscionable retreat from the rudiments of proper care of the elderly." [11]

On October 3, 1974, HEW published a series of amendments to the January regulations including the requirement for a patient's bill of rights. These and other actions have signaled to observers what may be a new and growing awareness by the Department to problems of the infirm elderly. This change in policy and the greater commitment were outlined in a June 21, 1974 speech by Under Secretary

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[10] See pp. 105–06 of the Introductory Report.

[11] Pages 45–54, Introductory Report.

Frank Carlucci when he announced a long-term care improvement campaign. His plan was as follows:[12]

1. Unannounced inspection of 304 randomly selected nursing homes around the Nation by HEW validation teams. Each team will have a physician, a registered nurse, a physical therapist, a nutritionist, a pharmacist, a fire and safety engineer, and a health care facility administrator. The team will spend a minimum of 2 days in each facility, assessing the quality of nursing home care. Creation of a long-term care management information system which can supply information rapidly about surveys, certification, inspections, and the status of individual homes.
2. Organization in regional offices of long-term care standards enforcement units and confirmation of responsibilities (*Federal Register*, June 13, 1974).
3. The August 30, 1974, *Federal Register* contains details of HEW's latest reorganization giving the Office of Nursing Home Affairs greater authority. Two divisions are created within the agency: (1) The Division of Standards Enforcement, and (2) the Division of Policy Development an Interagency Advisory Group under the Chairmanship of the Office of the Under Secretary and the Office of Nursing Home Affairs to coordinate long-term care activities.
4. Continuation of health facility surveyor improvement program as well as training of nursing home provider personnel.
5. The development of uniform inspections and a system of uniform ratings for nursing homes. A "scoreboard" rating of "A" for a facility would carry the same meaning in every State.
6. The establishment of monthly cost of care indices with separate estimates for skilled nursing care and intermediate care.

Even though Under Secretary Carlucci left the Department in December 1974 to take a post as U.S. Ambassador to Portugal, the long-term care improvement campaign has continued under the direction of Peter Franklin, Special Assistant to the Secretary and Dr. Faye G. Abdellah, Director of the Office of Nursing Home Affairs. The following is an update, progress report and commentary on each of the above points.

HEW's SURVEY OF 304 NURSING HOMES

On April 1, 1975, the Department released a 16 page interim report entitled, "Long Term Care Facility Improvement Study." It was based on what HEW calls a statistically valid sample of 295 (instead of 304) homes in 47 states with interviews of 3,458 patients.

The report cites widespread deficiencies "in U.S. nursing homes including overdrugging, inadequate medical attention, inadequate diets, poor rehabilitation programs, and fire safety violations." HEW spokesmen described this report as "the first solid data" on the existence of many nursing home abuses. HEW will issue additional findings from this survey at intervals.[13]

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[12] Pages 106–7, Introductory Report.

[13] *New York Times*, Apr. 2, 1975.

DISPUTE OVER CONFIDENTIALITY

The American Health Care Association (formerly American Nursing Home Association) made no comment on the substance of the report. However AHCA urged HEW to issue only one report instead of publishing its findings one by one. AHCA also asked the Secretary of HEW to release the raw survey data upon which the report is based. Ironically, it appears that HEW has not released the data because of a commitment made to the California Association of Health Facilities (the state nursing some association affiliated with AHCA). In an August 8, 1974 letter to attorneys for the Association, Carlucci assured the California association that survey information on individual facilities would be kept confidential.[14]

The Senate Finance Committee staff contended that the Department's intention to maintain the confidentially of survey findings is in clear conflict with Section 249 C (a) of Public Law 92-603. The pertinent section reads:

> (d) . . . the Secretary shall make available to each State agency operating a program under Title XIX and shall, subject to the limitations contained in subsection (e), make available for public inspection in readily accessible form and fashion, the following official reports . . . dealing with the operation of the health programs established by Titles XVIII and XIX—
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> * * * * * * *
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> (3) program validation survey reports and other formal evaluations of the performance of providers of services, including reports of follow-up reviews, except that such reports shall not identify individual patients, individual health care practitioners, or other individuals.

The Finance Committee Staff contends that the public disclosure provisions of Section 249 C (a) are applicable to "validation survey reports" and to "other formal evaluations of the performance of providers of services" participating in the Medicare and/or Medicaid program and that the survey undertaken by HEW of 295 facilities fall within the meaning of this provision because:

1. Under Secretary Carlucci described this activity as a validation survey. Specifically he said: "The first project will be a visit of 304 randomly selected nursing homes around the Nation by Regional Office and Headquarters validation teams."[15]
2. The facility survey forms used are based almost entirely upon the Federal regulations outlined in the "conditions of participation" of a skilled nursing facility in Medicare and/or Medicaid.
3. Only facilities participating in Medicare and Medicaid were utilized in developing this sample.
4. Only the records of Medicare and/or Medicaid patients have been reviewed.
5. Over one-half of the funds for the survey (some $450,000) is drawn from Social Security Trust Funds and from the appro-

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[14] Retained in committee files.

[15] Page 4, text of prepared remarks by Under Secretary of Health Carlucci at the meeting of State Surveyors, St. Petersburg, Fla., June 21, 1974.

priations of the Social and Rehabilitation Service (which administers Medicaid).

The staff argues that the clear intent of Congress in enacting this section of the law was to assure that the deficiencies of providers are brought under public scrutiny, "with the accompanying pressure for improvement in administration that only such awareness can bring."

In response, the Department claims that the survey was conducted under the authority of Section 306 of the Health Services Research, Health Statistics, and Medical Libraries Act of 1974. It characterizes its activity as "research" or "statistics" rather than a formal evaluation of provider performance. In calling such activity research, the Department alleges that it is bound by Section 308(d) of the above act to maintain the confidentiality of the providers in its survey.[16]

Senator Frank E. Moss, Chairman of the Subcommittee on Long-Term Care recently joined in asking release of the survey data. In a letter to HEW Secretary Caspar Weinberger, he charges that HEW is on "very weak ground" in attempting to claim that the survey was done under the authority of Section 306. In addition to the above reasons spelled out by the Finance Committee staff, he notes:

1. Section 306 establishes the National Center for Health Statistics within HEW. It states that "*the Secretary, acting through the Center*" may collect statistics on a wide range of health needs including illness and disability of the population of the United States. In this case the National Center for Health Statistics was not involved in the effort to any appreciable degree. Half of the funds came from Social Security Trust Funds (Medicare) and from the Social and Rehabilitation Service (Medicaid). The Remainder came from the following sources:

Alcohol, Drug Abuse, and Mental Health Administration	$113,500
Health Resources Administration	113,500
Health Services Administration	227,000
Total	454,000

2. The confidentiality provisions of Section 308(d) only apply in the case of information obtained in the course of health statistical activities. The survey activities, taking 2 days per facility, conducted by 7 man teams are by definition evaluative activities.

Senator Moss concluded his letter endorsing the "clear merit of such validation surveys" but stating that, "The Department should not be permitted to frustrate the intent of Congress by labeling the survey a "research project".[17]

HEW ENFORCEMENT ACTIVITY

Numbers 2, 3 and 4 of the Carlucci plan relate to plans to gear up the enforcement of Federal standards. H.E.W. placed major emphasis on the training of state inspectors. Through May of 1974, some 2,028 state surveyors had completed the 4-week training course designed to promote uniformity in inspection procedures and to instruct state inspectors in federal requirements. HEW directives continue to assure the states that they (the states) will continue to have the responsibility of assessing compliance with standards and for certifying facilities for participation in Medicare and Medicaid. However, recent developments indicate that HEW will take some of the burden of the inspection and enforcement process and that HEW will be much tougher with states that fail to enforce standards.

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[16] Letter to Jay Constantine, professional staff member, Senate Finance Committee; from Faye G. Abdellah, Director, Office of Nursing Home Affairs, dated Oct. 15, 1974.

[17] Letter dated Apr. 11, 1975.

To facilitate the enforcement of standards, HEW reorganized the Office of Nursing Home Affairs, extending the line of authority directly into the Office of the Secretary of Health, Education, and Welfare. Authority for overseeing enforcement was placed in the hands of the HEW Regional Directors, and standards enforcement units were set up in each region. One illustration of HEW's new commitment came on October 16, 1974 when it brought suit to compel the State of Pennsylvania to enforce Federal Standards.

HEW SUES PENNSYLVANIA

The Department of Justice, acting for HEW, brought the suit. Specifically asking for an injunction requiring the state to perform its functions in certifying nursing homes under Title 18 (Medicare) and Title 19 (Medicaid) of the Social Security Act. HEW's brief cites the example of two nursing home fires in Pennsylvania in 1974. One home was allowed to participate in Medicaid without a valid provider agreement principally because the home could not meet Federal minimum fire safety requirements. The second home participated in both Medicare and Medicaid although it could not comply with the fire safety provisions.

In all, HEW cites 134 Pennsylvania homes allowed to participate in Medicaid without the required valid provider agreements. Some 52 facilities were allowed to participate in Medicare without providing HEW with assurances that they qualify for certification in the program.

HEW withheld $12 million in Federal matching funds because the homes to receive the money had not been satisfactorily inspected and certified in compliance with Federal standards as required by Law.[18]

Obviously, the State of Pennsylvania has its own version of these facts and is vigorously contesting the HEW action in the Federal District Court for Middle Pennsylvania.

NEW YORK: HEW CUTS OFF FUNDS TO SPECIFIC HOMES

Despite the clear language a 1967 Moss amendment requiring the Secretary to cut off Federal funds to facilities which did not fully meet state licensure requirements, HEW has contended that it lacks authority to cut off funds from specific homes.[19] Until January 1975, HEW officials reasoned that they could cut off funds only to an entire state (such as Pennsylvania). Clearly this action can be criticized as unfair, as it is unpractical except in large scale cases involving violations by a great many facilities.

This reasoning on the part of HEW was reinforced by recent Court decisions which have held that a nursing home license (and even a certification for participation in Medicare and/or Medicaid) is a property right which cannot be breached without due process of law. The extreme case is probably before the California Supreme Court.[20] In that case the provider agreement between the facility and the state expired.

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[18] Oct. 16, 1974, letter to Senator Frank Church from Secretary Weinberger, including copy of HEW brief against State of Pennsylvania.

[19] Public Law 90-248, Section 234.

The State announced its intention not to renew the contract. The nursing home brought suit, charging that the decision not to renew (as opposed to terminating an agreement presently in force) was a property right secured by the due process clause. The State contends that no administrative hearing is necessary in its decision not to renew the contract for participation in Medicaid. The nursing home claims the opposite.

In New York a similar suit has been brought by the nursing home association against H.E.W. January action cutting off Federal funds to specific homes. The Association suit employs the same due process argument. H.E.W. relies heavily on the federal fire safety standards (compliance with the Life Safety Code of the National Fire Protection Association). H.E.W. contends that the Secretary of H.E.W. has specific funds to accept or deny waivers of Life Safety Code requirements granted by the States. Moreover, according to Federal Regulations H.E.W. can cut off Federal funds to individual homes 30 days after it notifies the state of the termination of a home's provider agreement.[21]

Not all parties have been happy with H.E.W.'s new enforcement policy even though the authority has not been used in other states. Many states have written to H.E.W. in opposition to proposed regulations which transfer the authority to issue waivers from the State survey agency to H.E.W. While H.E.W. describes the intent of this move as insuring uniformity in the granting of waiver, some states view it as usurpation of state police powers. Accordingly, it remains to be seen how long H.E.W.'s resolve continues in the face of such stress.

Other Developments

No data has been received by the Subcommittee with respect to H.E.W.'s progress in establishing a uniform rating system for nursing homes or for developing monthly cost of care indices. Both are positive and important developments and, it is hoped, will be implemented in the near future. Some progress, however has been made on other fronts:

Administrator Licensure.—The U.S. Circuit Court of Appeals recently upheld H.E.W.'s regulations which require that State Nursing Home Licensure Boards may not be dominated by members of the nursing home industry or their surrogates.

Fire Safety Loans.—Officials in H.E.W. were influential in helping the passage of a bill introduced by Senator Moss which provides F.H.A. insurance for the purchase of fire safety equipment. As administered by H.U.D. the term "equipment" is defined broadly in the regulations so that many "fire safety related improvements" are covered. Both for-profit and non-profit facilities are eligible. Most mortgages are amortized over a 15 year period and interest cannot exceed 9 percent.[22]

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[20] *Paramount Nursing Home vs. Department of Health Care Services;* no opinion has been rendered as of this date.

[21] See *Federal Register*, Nov. 13, 1974, and HEW press release dated Jan. 8, 1975, issued at New York press conference by Peter Franklin, Special Assistant to the Secretary. See also Federal Register, Feb. 11, 1975, for proposed regulations transfering authority for allowing waivers from State agencies to the Secretary of HEW.

Section 222 Demonstration Projects.—In September H.E.W. awarded seven contracts totalling $1,862,276 for experiments to test the potential of providing Federal reimbursement for homemaker and day care services.[23] These demonstration projects were mandated by Section 222 of Public Law 92–603 passed in October of 1972.

Home Health Care.—In January 1975 Secretary Weinberger told the Legislative Counsel of the American Association of Retired Persons that home health care is under-funded. "Because home health services have been under-financed by government, programs like Medicare and Medicaid and public medical assistance provide home health service benefits for only a narrow segment of the older population. That is the way laws are written." [24]

Home health is likely to stay under-funded in this administration as projection for fiscal year 1976 place Medicare home health expenditures at $148 million or still less than one percent of medicare's projected $15.5 billion total in that year. Moreover, few legislators would accept the Secretary's reasoning that the law is the limitation. To be more precise, it is administrative regulations which now restrict coverage of what was a viable program.[25]

Regulations for Section 247—Assigning Levels of Care.—Drafts are currently circulating in H.E.W. which suggest that H.E.W. is on its way to liberalizing administrative regulations which restrict access to treatment under Medicare home health and nursing home benefits. Legislation has also been introduced by Senator Moss, Senator Frank Church, chairman of the Committee on Aging and Senator Pete Domenici, with companion legislation sponsored by Ed Koch in the House of Representatives.[26]

All in all, these efforts suggest a welcome and refreshing willingness to assume responsibility by the Department of Health, Education, and Welfare. The steps are few, but compared to the inaction and neglect and indifference which characterized previous HEW policy, they loom large against the horizon.

V. LEGISLATION

On March 12 Senators Moss, Church, and Domenici introduced the first 12 of what Senator Moss called a 48-bill package on nursing home reform. Congressman Ed Koch sponsored these bills in the House. Essentially, the proposed bills fall into 6 categories:

—Measures to provide increased home health and nursing home benefits, to give family members "options" beyond nursing home placement.

—Proposals to provide training for the present and future generation of physicians in geriatrics and the care for nursing home patients.

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[22] See *Federal Register*, June 6, 1974, for full regulations.

[23] HEW news release, Sept. 30, 1974.

[24] *Home Health Highlights* report of the National Association of Home Health Agencies, Jan. 24, 1975, pp. 1–3.

[25] The *Proposed Fiscal 1976 Budget: What it Means for Older Americans*, U.S. Senate Special Committee on Aging, February 1975, p. 8.

[26] S. 1163.

Training programs for nursing home personnel.

New Federal minimum standards.

New enforcement tools to help discipline nursing homes short of licensure revocation.

Legislation to tie together nursing home reimbursement with the quality of the care provided.

Some proposals stem directly from the Committee's hearings in New York. For example the proposal to require nursing home operators to file C.P.A. (Certified Public Accountant) audited financial statement yearly with fines and penalties for fraud or misrepresentation of a material fact.[27] Another proposal would require the disclosure of each and every nursing home interest (instead of only interests above 10 percent) with penalties for misrepresentation.[28]

Other bills implement recommendations made in Subcommittee's reports, such as broadened home health benefits, for subsiding the family to care for their elderly in their own homes and authorizing day care under Medicare. (For full details of these bills, see pp. S. 6927–28, Cong. Rec., April 29, 1975.)

VI. REACTION FROM NURSING HOME SPOKESMEN

Initial reaction from nursing home spokesmen to the Subcommittee's reports was one of anger and distress. This response was largely a reaction to the press accounts of the Subcommittee's report rather than to the reports themselves. Upon closer examination of the reports, many nursing home spokesmen have praised the reports. Typical of such response is the following letter from Mr. George W. Akers, Vice-President of Hillhaven Nursing Home Chain.[29].

HILLHAVEN,
Tacoma, Wash., December 19, 1974.

Re: "Nursing Home Care in the United States: Failure in Public Policy—Introductory Report" Prepared by the Subcommittee in Long-Term Care.

Hon. FRANK E. MOSS,
U.S. Senate,
Washington, D.C.

DEAR SIR: While reading, in the December 10 Congressional Record, your overview of the above publication, my original impressions regarding the Subcommittee's "Introductory Report" were reaffirmed and I am moved to share them with you.

The objectivity with which the Subcommittee has conducted its investigations and published its findings is most appreciated and indeed to be congratulated. The "Introductory Report" reflects this objectivity and contains background and statistical data which is obviously factually sound and which is also "eye-opening" to say the least.

Problems within the nursing home industry have long been guessed at by all sectors, public and private. The members and staff of the Subcommittee on Long-Term Care are to be commended for going beyond the guessing stage and for developing a program for publishing factual analysis of problems and causes—analysis from which workable resolutions may be planned.

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[27] S. 1164.

[28] S. 1166.

[29] Reprinted in the *Congressional Record*, Mar. 21, 1975, p. S. 4760.

Our organization, nationally representing approximately 7,800 long-term care beds, desires and intends to actively contribute to such resolutions and we are looking forward to receiving and responding to the Subcommittee's projected Supporting Papers. The Subcommittee's "unusual plan of action" affords us and others this unusual opportunity. For this we wish to express our appreciation to you, Senator Moss, as Chairman and to the members and staff of the Subcommittee on Long-Term Care.

Sincerely,

George W. Akers,
Vice President.

Non-profit church related facilities have taken exception to the Subcommittee's general use of the term "the nursing home industry". They assert, that they spend proportionately more for food and for professional nursing services and thus offer a higher quality of care. While for-profit spokesmen might dispute this claim, both groups have agreed on the need for wide-scale nursing home reforms.

The American Health Care Association has set aside $375,000 for a "public relations" campaign to be conducted this year. Initial concerns that this was some kind of "war chest" appear not to be justified.[30] AHCA has taken the unusual step of printing and offering for sale the Subcommittee's Introductory Report at $1.50 per report and each of the Supporting Papers for $1 each. This step was taken partly out of frustration of being able to receive the reports from the Committee, which quickly exhausts its supply of each volume. Reports are available from the Government Printing Office at $1.75 for the Introductory Report and Supporting Papers vary in price from $1.25 to $.85.

AHCA has also sponsored a national conference on long-term care which is intended to help fashion solutions to the problems in the field. The conference held jointly with George Washington University will be held in Washington, D.C. on June 11–15.

Health care providers are looking forward to the publication of the Subcommittee's report on positive aspects in long-term care in late May, and individual organizations spokesmen are planning to provide comments for inclusion in the Subcommittee's 11th report.

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[30] See p. 224 of Supporting Paper No. 1, "The Litany of Nursing Home Abuses and an Examination of the Roots of Controversy."

CHAPTER V

RECESSION, AS WELL AS INFLATION: PROBLEMS RELATED TO EMPLOYMENT

Inflation, as described in Chapter II, has caused severe problems for older persons on limited and often fixed incomes.

They face high prices on essential services and goods. They also face shortages of important commodities.

But inflation is not the only economic disorder which intensifies problems related to aging.

Recession also takes its toll, most notably among so-called "older workers," men and women who may be years away from retirement age, but who nevertheless bear a disproportionate share of unemployment caused by layoffs, plant shutdowns, and firings.

In fact, the sharpest upturn in unemployment among this group in the last 12 years occurred during 1974.

Problems related to recession also are surfacing in age discrimination enforcement. Even though impressive gains were made in implementing or improving the Age Discrimination in Employment Act of 1967, a tendency to encourage, or even insist upon, early retirement emerged as employers—including public agencies—attempted to cope with hard times.

I. THE UNEMPLOYED "OLDER WORKER"

Growing unemployment [1] deepens two persistent dangers for middle-aged and older workers, those aged 45 and above. One is the long-standing attitude that older workers should be released first in difficult economic times in order to "make way for the younger worker." Another is the widespread awareness of the special and acute problems confronting older workers once they enter the jobless rolls. Usually their period of unemployment is longer than for younger workers. And their opportunity for returning to similar work with comparable pay is considerably diminished.

A. 1.5 Million Unemployed Middle-Aged and Older Workers

Throughout most of 1974 unemployment for persons in the 45-plus age category fluctuated between an 800,000 and 900,000 band. Beginning in July the joblessness level began to leap forward. By December the number of unemployed middle-aged and older persons reached 1,229,000—the highest level since December 1962.

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[1] Statistics on unemployment and inflation in this chapter have been obtained from the Department of Labor, primarily through telephone conversations.

And the situation deteriorated markedly during early 1975. In January more than 200,000 mature workers were added to the unemployment rolls, pushing the level to 1,452,000. By March the figure edged up to 1,535,000.

But these figures—depressing as they are—really understate the true dimensions of the joblessness picture for older workers.

One important reason is the substantial amount of hidden unemployment among persons in the 45-plus age group. In general, the unemployment figures reflect only those who are actively seeking work, not those who have dropped out of the labor force, usually after prolonged and fruitless searches for work.

As of March 1975, there were nearly 3.1 million men aged 45 to 64 who were not in the labor force and 11.5 million women in this age category who were similarly situated. Assuming that just 25 percent of these men and 5 percent of these women (probably conservative estimates) wanted and needed employment, this would increase the "statistical" joblessness for persons 45 and above by more than 1.35 million.

Thus, it is conceivable that the "real" unemployment for middle-aged and older workers is approaching 2.9 million, or nearly 9 percent. And these figures would not even include the "hidden" unemployed among the 65-plus age group.

Second, once unemployed, the mature worker runs a substantially greater risk of being without a job for a comparatively long period of time. Typically a jobless older person can expect to be unemployed anywhere from 30 percent to 70 percent longer than other workers.

During 1974 the average duration of joblessness for all unemployed persons was 9.7 weeks. However, it was considerably protracted for middle-aged and older workers.

For jobless individuals age 45 to 54 the average duration of unemployment was 12.9 weeks; for those in the 55 to 64 age category it was 15.2 weeks; and for persons 65 and above it was 16.6 weeks.

B. UNDER-REPRESENTED IN FEDERAL MANPOWER PROGRAMS

Despite the pressing and sometimes unique problems confronting older workers, they have characteristically been under-represented in our Nation's manpower efforts.

In 1974 persons 45 and above accounted for only about one out of every 23 new enrollees (4.4 percent) in Federal job and training programs. This figure represented a decline from the 5.6 percent level in 1973, when middle-aged and older workers comprised nearly one out every 18 new enrollees.

Yet, persons 45 and above (as of December 1974) constituted 19 percent of the total unemployment in the United States, 27 percent of the long-term joblessness (15 weeks or longer), and 39 percent of the very long-term unemployment (27 weeks or longer).

Moreover, enrollment declined from 82,000 in 1973 to 79,900 in 1974, although unemployment increased substantially.

TABLE A.—ESTIMATED ENROLLMENT OF PERSONS AGED 45 AND OVER AND 55 AND OVER

	New enrollment	Enrollees (45 yrs and over)		Enrollees (55 yrs and over)	
		Number	Percent	Number	Percent
Total	1, 803, 900	79, 900	4. 4	26, 500	1. 5
Work incentive program	353, 100	37, 400	10. 6	5, 300	1. 5
Concentrated employment program	70, 100	2, 900	4. 2	1, 000	1. 4
Manpower Development and Training Act (institutional)	110, 400	6, 100	5. 5	1, 200	1. 1
Job opportunities in the business section	29, 200	1, 100	3. 7	INA	INA
Jobs optional program/on-the-job-training	63, 100	4, 200	6. 7	1, 200	1. 9
Public employment program	66, 200	7, 100	10. 7	2, 100	3. 2
Operation Mainstream	41, 900	20, 200	48. 3	15, 400	36. 8
Public service careers	9, 600	900	9. 2	300	2. 9
Jobs Corps	45, 600				
Neighborhood Youth Corps:					
In school	163, 400				
Out of school	71, 600				
Summer	577, 000				
Public employment program (summer)	202, 700				

Office of Administration and Management, Division of Reporting Operations, Department of Labor, Feb. 19. 1975.

C. WHAT EARLIER RETIREMENT REALLY MEANS

Older workers frequently discover that they are the first to be fired and the last to be hired during a recession, especially those who are not protected by seniority. In part, this practice is based upon the notion that older Americans have pensions to provide a "cushion."

But the harsh reality is that earlier retirement means actuarially reduced Social Security benefits at 6⅔ percent per year for each full year before 65. Yet, these individuals are the ones who often can least afford a cut because they typically have little outside income to supplement their Social Security. And, Social Security benefits are still very low in many cases: the average monthly payment for a retired worker (without dependents) amounts to $183, which is below the poverty threshold (see chapter II).

Moreover, the vast majority of retirees do not have private pensions to supplement their Social Security. Only one out of four couples receiving Social Security benefits and one out of ten nonmarried beneficiaries also receive private pensions. Even when benefits from other Federal programs are considered, only one out of three of the couples and one out of six of other beneficiaries have a second pension.[2]

NEW YORK CITY EXAMPLE

Pressure for earlier and earlier retirement mounted as the recession intensified in 1974. One notable example was the New York City plan (proposed on December 12, 1974), to retire employees at age 63, instead of 65. In large part, this recommendation was designed to cut the city government's costs, which had swollen because of inflation and an increase in the welfare rolls from the expanding unemployment.

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[2] Social Security Administration.

Supporters of the city's proposal contended that most older workers would receive a pension and Social Security. However, the New York City Office on Aging pointed out that early retirement might cause the average employee a loss of $40,000 or more over his lifetime. In almost every case the employee's pension and Social Security benefits would fall considerably below prior earnings. Moreover, earlier retirement would mean a permanently reduced Social Security benefit for the rest of the retired worker's life.

Forced retirement at an earlier age not only causes financial hardships for the older worker and his family, but it can also be psychlogically damaging as well.

This is especially true when the individual has been forced to retire involuntarily. And with unemployment continuing to increase, the likelihood of obtaining gainful employment is minimal.

Representatives of the New York City government were informed by the Department of Labor that the early retirement plan would violate the Age Discrimination in Employment Act. On December 18, 1974, the Department of Labor ruled that the plan was illegal. Several alternative plans, however, were under consideration in 1975.

II. EMPHASIS ON THE AGE DISCRIMINATION IN EMPLOYMENT ACT

The Congress and the courts gave significant attention to the Age Discrimination in Employment Act (ADEA) over the past year.

Excluded as a category under the Civil Rights Act of 1965, age discrimination was generally neglected until the passage of ADEA in 1967.[3] The Act prohibits discrimination on the basis of age for those at least 40 years of age but less than 65 years of age in hiring, job retention, compensation, promotions and other conditions and privileges of employment.

A recent upsurge in job layoffs and unemployment, as described earlier in this chapter, has caused many older workers to seek the protections and provisions of the ADEA. The Department of Labor's Wage and Hour Division, which has administrative responsibilities for the Act, estimates that out of the 91.4 million persons in the labor force approximately 36.7 million are in the age 40–65 group and therefore protected by the ADEA. During 1974 the Wage and Hour Division conducted approximately 7,983 investigations in 7,535 establishments. Monetary violations estimated at $6.3 million where uncovered in 277 establishments involving 1,648 employees. Income was restored to 637 employees in the amount of $2.5 million in 110 establishments. Nonmonetary discriminatory practices were disclosed in 2,680 establishments where 2,744 employees were aided.[4] Of the complaints investigated, discriminatory practices were found most often in illegal advertising, followed by refusals to hire, and illegal discharges.

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[3] Public Law 90–202 was signed into law on Dec. 15, 1967.

[4] As reported in *Age Discrimination in Employment Act of 1967, A Report Covering Activities Under the Act During 1974*, Submitted to Congress in 1975 in Accordance With Section 13 of the Act, Employment Standards Administration, Department of Labor, Jan. 31, 1975.

A. LEGISLATIVE PROGRESS

Incorporating recommendations of the Senate Committee on Aging, the Fair Labor Standards Amendments of 1974 (Public Law 93-259) included several provisions which amended the Age Discrimination in Employment Act:

Extension of coverage of the ADEA to Federal, State, and local employees.

A broadening of the application of the Act to include private employers with 20 or more employees (instead of 25 as under prior law).

An increase in the authorized funding level from $3 million to $5 million.

However, the Administration's budget request in January 1975 for $2.2 million was far below the authorization level of $5 million.

Other legislative proposals introduced during 1974 would eliminate the 65 age ceiling of the ADEA; amend Title IX of the Higher Education Amendments of 1972 to prohibit discrimination on the basis of age in education programs or activities receiving Federal financial assistance; amend Title VII of the Civil Rights Act to include prohibition of discrimination on the basis of age; and amend the Equal Credit Opportunity Act to include provisions disallowing age discrimination.[5]

Early in the 94th Congress, the House approved legislation (H.R. 3922) to amend and extend the Older Americans Act through fiscal 1979. The legislation included a title which would prohibit age discrimination on the basis of age (any age) in any program or activity receiving Federal financial assistance. However, the proposed Act would not apply to special emphasis programs to meet the needs of particular age groups, e.g. the Mainstream program, Nutrition Program for the Elderly and Job Corps. Any agency or department awarding Federal contracts or grants, would be responsible for drawing up regulations prohibiting discrimination on the basis of age in those programs receiving Federal assistance. If such a recipient of Federal assistance failed to comply with the age discrimination law and regulations, enforcement action could result in termination of Federal financial support.

The House passed H.R. 3922 on April 8.

Although most of the other age discrimination bills introduced in 1974 were not acted upon by the Congress, interest in the issue appears to be high in 1975. Identical legislation has been introduced in the 94th Congress, and it is expected that several measures will be acted upon.

B. ACTION BY THE COURTS

During 1974, 47 suits were filed under the provisions of the ADEA. Several cases resulted in actions which gave severely needed support to the ADEA and its enforcers. Among the most significant and influential cases were:

The Standard Oil Company of California's unit of Western Operations, Inc. was directed by the court to pay $2 million to 160 former employees and to reinstate 120 of the employees whom the court found were discriminated against on the basis of age (May 1974).

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[5] S. 2499 and H.R. 17383, H.R. 17009, H.R. 8840, and H.R. 17555, respectively.

The Exxon Company was ordered by the courts to pay $750,000 in damages to the estate of a former employee who had unwillingly been retired at the age of 60. It allegedly had been part of the company's policy to ease out older, higher-paid executives and replace them with younger workers, (February 1975).

Still unsettled but extremely significant in importance is the Department of Labor's suit against the Chessie System Inc.'s railroads, the Baltimore and Ohio and the Chesapeake and Ohio, where DOL is alleging that the railroads are guilty of firing, demoting, or denying work to 300 supervisory workers on the basis of their age. The Department is requesting $20 million in damages. Of major significance in this case, is DOL's attempt to eliminate the railroad's mandatory retirement age of 62 in their pension plans (filed June 1974).

A major setback to enforcement of age discrimination statutes took place when the Supreme Court denied a writ of certiorari filed by the Department of Labor with regard to *Brennan* vs. *Greyhound Lines*. The Court let stand a ruling that an inter-city Greyhound bus line does not violate the ADEA by refusing to hire new drivers over 35 years of age (January 1975).

FINDINGS AND RECOMMENDATIONS

New employment legislation to help older workers should be effectively administered and adequately funded. And special provisions for the elderly—such as the authorization for public service jobs for older Americans and handicapped individuals who are unable to work full time because of age or a disability—should be promptly implemented.

The committee recommends that the administration's budget request for the Age Discrimination in Employment Act be raised to an amount more consistent with the authorized funding level. Additionally, the committee urges vigorous enforcement of the 1974 amendments and other provisions in the age discrimination law. The committee also endorses the provisions of S. 3922 calling for a prohibition of age discrimination in any Federal program.

Finally, the committee calls upon the Department of Labor to adopt sound policies to overcome the gross under-representation of older workers in manpower and training programs, as well as to encourage State and local governments to take similar concrete affirmative action.

CHAPTER VI

LANDMARK LEGISLATION ON HOUSING, BUT SLOW PROGRESS AND NEW PROBLEMS

Congress and the Administration—after four years of disagreement and stalemate—finally passed a housing act in 1974.

That important legislation, the Housing and Community Development Act of 1974 (Public Law 93-383), provided $11.9 billion over three years. It is designed to implement a new overall block grant strategy.

Housing needs of older Americans were recognized with a "revised" Section 202 program to enable sponsors to build specially designed, subsidized housing for the elderly, in conjunction with a new Section 8, program intended to provide help for renters.

But enactment of a law is one thing. Implementation is another.

Early in 1975 would-be sponsors under 202 were urging the Department of Housing and Urban Development (HUD) to take unmistakably affirmative steps to fulfill Congressional intent. And yet at this writing, supporters of 202 still await final regulations.

In addition, HUD is being asked whether 202 with Section 8 will guarantee the availability of long-term financing. HUD has indicated their intention to use this program solely for construction financing.

These questions and others have brought requests for new HUD Secretary Carla Hills to give them early attention, and she has promised to do so.[1]

Even as HUD and its critics dealt with issues arising from enactment of legislation, housing problems deepened for many Americans of all ages, but particularly for the elderly.

Major increases in the costs of fuel and utilities have resulted in sharp rent rises and desperate situations for older persons in many parts of the nation.

For example:

—After going several years without a rent hike, a New Jersey Section 202 project will soon have its second one in a year.

—HUD recently approved a 48 percent rent increase at a federally assisted project in New York City.

—And in that same city, the Housing Authority reported an increase in fuel oil costs from $18 million in 1973 to a projected $43 million for this year.

Letters from elderly tenants and homeowners reach this Committee and the offices of members of Congress.

They ask: Where will we go when the next rent increase comes and we can find no way on earth to pay it?

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[1] Meeting with Secretary Hills and spokesmen for elderly, Apr. 4, 1975.

I. THE 1974 HOUSING ACT: WHAT'S IN IT FOR OLDER AMERICANS?

As enacted last August 22, P.L. 93–383 embraces a strategy calling for "flexible" block grants to replace the old categorical grant programs such as urban renewal and Model Cities.

The subsidized housing spigot—turned off by a housing freeze declared by the Administration in early 1973—has been turned on once again. Old programs have been given only a very limited new lease on life, however, because the new bill places great emphasis on a substantially expanded, subsidized-leasing program known as Section 8.

A. The Housing Assistance Payments Program: Section 8

In September 1973, the Nixon Administration identified direct cash assistance, or housing allowances, as the "most promising" approach for meeting the housing needs of lower-income families. The Ford Administration endorsed this policy,[2] and HUD soon designed a Section 8 program intended to provide both new and existing subsidized housing in a manner as consistent as possible with the direct cash assistance approach.

Very simply, Section 8 allows the Federal Government to contract with private owners to pay the difference between (1) the fair market rent and (2) the amount the tenant is required to pay which is not less than 15 percent nor more than 25 percent of the family's adjusted income. The new Act authorizes HUD to approve such payments for 400,000 units for fiscal year 1975. Separate regulations have been provided under Section 8 for varying sites: new construction, substantial rehabilitation, and existing housing.

As conceived by the Administration, the new Housing Assistance Payments Program would replace all the old subsidized programs (public housing, Section 236, and Section 202) as the vehicle for new approvals. The advantages to this new approach, as argued by the Administration, include:

—Costs can be better controlled because rents will be determined by the market; competition will exist between private developers and local housing authorities, and payments will be made only for units which are occupied;

—The lowest-income family can be reached since the formula will always pay the difference between what a family can afford and what it costs to rent the unit;

—Eligible families will have more freedom of choice to negotiate with various landlords instead of being limited to particular projects in set locations; and

—Maintenance and operation will be improved because the owners will have full responsibility for all management functions including tenant selection and rent collection.

Other features of Section 8:

(1) In order to prevent large concentrations of low-income housing in one area, preference is given to projects which request subsidy

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[2] White House Press Release, "The Housing and Community Development Act of 1974 (S. 3066)—Fact Sheet," Aug. 22, 1974.

for less than 20 percent of the units. However, projects for the elderly which are 100 percent subsidized will share the same priority level as non-elderly projects that are partially subsidized.

(2) Tenants are eligible for assistance if their income does not exceed 80 percent of the median income for the area.[3]

(3) In addition, at least 30 percent of the families assisted annually must have gross income not in excess of 50 percent of the median income for the area.

(4) The Conference Report on the new Act expresses the Congressional expectation that HUD will take into account the need to provide housing with suitable amenities and sound architectural design in establishing fair market rents.

B. THE REVISED SECTION 202 PROGRAM

First introduced as part of the Housing Act of 1959, the original 202 program offered direct 3 percent government loans (for 50-year terms) to non-profit sponsors. The low interest rate made possible very reasonable rents for low- and moderate-income elderly. This program successfully built more than 45,000 units (330 projects) with only one mortgage foreclosure. Unfortunately, the "old" 202 program came under severe administration criticism because of its apparent impact on the national budget: every dollar loaned had to be appropriated by Congress. Consequently, in 1969 this program was suspended, by executive order, in favor of the newly created Section 236 "interest-subsidy" program. In January 1973, Section 236 was frozen as part of the housing moratorium declared by the Nixon Administration. Since that time there has been no program for building subsidized housing for older Americans.

Senator Harrison A. Williams, as he had done in previous years, introduced a bill (S. 2185) in July, 1973, to extend the authorization level of the original 202 program by $100 million.[4] Prior efforts to renew the "3 percent" 202 program had been unsuccessful, however, and it soon became clear that some revision of the original concept was in

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[3] The 1970 Census reveals the following median incomes for the cities and standard metropolitan statistical areas listed:

Area	City			SMSA		
	Median	50 percent	80 percent	Median	50 percent	80 percent
Boston	$9,133	$4,567	$7,306	$11,449	$5,275	$9,159
New York	9,682	4,841	7,747	10,870	5,435	8,696
Miami	7,304	3,652	5,843	9,245	4,622	7,396
Washington, D.C	9,583	4,792	7,664	12,933	6,467	10,346
Atlanta	8,399	4,200	6,719	10,695	5,347	8,556
Chicago	10,242	5,121	8,194	11,931	5,966	9,545
Fargo	10,175	5,088	8,140	9,599	4,799	7,677
Denver	9,654	4,827	7,723	10,777	5,389	8,622
Phoenix	9,956	4,978	7,964	9,856	4,928	7,885
Los Angeles	10,535	5,268	8,428	10,972	5,486	8,778
San Francisco	10,503	5,252	8,402	11,802	5,901	9,442
Seattle	11,037	5,519	8,830	11,676	5,838	9,341
Salt Lake	8,818	4,409	7,054	9,952	4,976	7,962

NOTE.—The median income figures for the city and SMSA were obtained from the U.S. Department of Commerce, Social and Economic Statistics Administration, Bureau of the Census, vol. 1, 1970 Characteristics of the Population, pt. 1, U.S. Summary, ch. C: General Social and Economic Characteristics, table 184.

[4] See *Congressional Record*, July 14, 1973, at p. S. 13474.

order. Revision took many months and involved careful consideration and input from many sources.[5] Finally, a new approach offered three distinct advantages:

(1) It did not require a direct appropriation, and would not increase the national Budget;

(2) It would combine with the new Section 8 Housing Assistance Payments Program (see above) so favored by the Administration; and

(3) It would provide assistance to elderly persons with much lower incomes than had previously been possible.

Instead of Congress appropriating money, the revised 202 program authorizes the Secretary of Housing and Urban Development to borrow from the Treasury up to $800 million, which can then be loaned to eligible sponsors of housing for the elderly or handicapped.

Eligible sponsors include nonprofits, limited dividend organizations, consumer cooperatives, and public agencies.

No longer will the loans be made at 3 percent. Instead, loans will be made to sponsors at the prevailing Government interest rate, plus an amount to cover administrative costs on the loans. Today, that interest rate is estimated between 7 and 8 percent. In effect then, the funds are paid back to the Government at the same rate it took for Government to borrow the money in the first place. In this way there should be no loss to the Treasury Department in the transaction.

However, with the end of 3 percent loans, low rental schedules for poor elderly would not be possible. This is where Section 8 comes into play. The new Act clearly intends for the Section 8 program to be used in tandem with the revised Section 202. As explained previously, the most important feature of Section 8 is that eligible tenants will not pay more than 25 percent of their income for rent.

In short, the 1974 Act creates a revised program—a combined Section 202/Section 8 mechanism—that preserves many of the advantages of the original 202 program and, at the same time, provides greater rental assistance to older Americans, including those in the very lowest income range.

Perhaps the advantages of this new approach can best be illustrated with an example. Assuming a newly constructed housing project for the elderly, a tenant with a monthly income of $200 would pay the following for a one bedroom apartment:

	Rent with 3 percent loan (estimated)	Rent with 8½ percent loan (estimated)	Tenant pays
Old 202	$120		$120.
Revised 202 (with sec. 8)		$200 (or higher)	$50 (or 25 percent of income).

Even though the revised 202 program does not require an actual appropriation of funds, the annual "level of borrowing" must be approved by the Appropriations Committees. In a Supplemental

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[5] Former Congressman Robert Steele, as Chairman of the House Republican Task Force on Aging, led the push for a renewed 202 in the House. He had the full backing of the House Republican Policy Committee.

Appropriations Act for Fiscal Year 1975 (H.R. 16900) the Congress approved a borrowing level for 202 of $215 million. This funding amount is made up of two parts: (1) $100 million from the total of $800 million authorized in the new Act, and (2) $115 million from the old 202 "revolving" fund.[6]

How does the $215 million approval translate into units? Per unit construction costs vary from region to region, but using a reasonable estimate of an average of $20,000 per unit, the Fiscal Year 1975 funding would produce 10,750 units (or approximatey 70 projects). Should Congress, in the future, approve the full $800 million authorization on top of the revolving fund, an estimated 45,750 units could be built (or more than 300 projects).

In the Report accompanying the Supplemental Appropriations Act, the Senate expressed its intent that the new Section 202 program be used in conjunction with the new Section 8 leasing program.[7] Significantly, the Committee stated:

> * * * the new Section 202 program should be employed as the primary vehicle for providing housing for the elderly, and [it should] not be a residual program to be used only when other programs fail.[8]

C. Other Relevant Provisions of the 1974 Act

The new strategy for Community Development represents perhaps the most fundamental change contained in the new Act. For housing, the old programs—while still alive—are given only a very limited future, and HUD continues to pursue its efforts to study the direct cash assistance program as a long-range goal.

COMMUNITY DEVELOPMENT—THE NEW BLOCK GRANT PROGRAM

The new Community Development approach is, in essence, a "special" revenue sharing program wherein block grants are awarded to local units of government to assist them in combating specified problems including the elimination of slums and blight, and the conservation and expansion of the nation's housing stock to provide a decent home and a suitable living environment for all persons. This new block grant program replaces seven categorical aid programs such as urban renewal, Model Cities, Water and Sewer Facilities, and the Neighborhood Facilities program.

The new bill authorizes $8.6 billion over three years for Community Development. For Fiscal Year 1975, Congress has appropriated over $2.1 billion for this purpose.[9]

No grant of funds under Community Development may be made unless an application has been submitted, including a "housing assistance plan" which accurately surveys the condition of the housing stock in the community and assesses the housing assistance needs of lower-income persons (including the elderly).

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[6] Under the original 202 direct loan program, loans are continually being repaid (principal plus 3 percent). These payments are paid into a "revolving" fund. The initial intention was to loan these monies out again as they came in. Instead, HUD has allowed them to accumulate to an estimated level of $115 million as of last fall.

[7] Senate Report No. 93–1255, to accompany H.R. 16900, Supplemental Appropriations Bill, 1975, Oct. 9, 1974, at p. 9.

[8] Page 9, report cited in footnote 7.

[9] Public Law 93–554.

Section 105 of the Act defines what activities are eligible for assistance.

An application submitted by a community may include plans for the acquisition, construction, or reconstruction of neighborhood facilities and senior citizen centers. Other eligible activities include special projects directed toward the removal of architectural barriers which restrict the mobility of the elderly and handicapped.

The new Act also permits the use of Community Development funds to finance public services; however, it must be clear that such services are not available through other forms of Federal assistance.

Eighty percent of funds will go to metropolitan areas and 20 percent to non-metropolitan areas. For the next three years no city will receive less under the combined block grant approach than it was receiving under the various categorical programs (the so-called "hold harmless" provision).

CONVENTIONAL PUBLIC HOUSING

A total of $1.225 billion in new contract authority is authorized for public housing under the new Act. However, the large bulk of this amount will go to finance the Section 8 Housing Assistance Payments program. Latest estimates predict that 38,000 units of conventional public housing will be approved in Fiscal Year 1975, followed by approval of only 6,000 units (Indian housing) for 1976.[10] There is no budgetary request for additional authority for this program because HUD wishes to use the Section 8 program instead.

Despite HUD's reluctance to continue the public housing program, the new Act did encourage important programs in the public housing sphere.

For the first time, the law specifically approves the use of operating subsidy funds for security services including the cost of security personnel. This new language is the outgrowth of the Housing Security Act of 1973 (S. 2180)[11] introduced by Senator Williams. Further language in the Act requires HUD to consider the factor of security in developing prototype costs for public housing units.

Congregate housing—defined as housing in which some or all units lack kitchens, and connected with which there is a central dining facility—is also emphasized in the Act.

The Secretary of HUD is required to encourage public housing agencies to provide this type of housing for the elderly.[12]

Several other public housing provisions are of interest to the elderly including the following:

(1) For the first time *minimum* rents have been established at 5 percent of gross income, or that portion of a welfare payment specified to meet housing needs, whichever is greater.

(2) No bill language specifies the amount to go for modernization; however, there is report language explaining Congressional intent that $40 million be used for this purpose in Fiscal Year 1975.[13]

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[10] Summary of The HUD Budget Fiscal Year 1976, U.S. Department of Housing and Urban Development, Office of the Budget, February 1975, at p. I-7.

[11] See *Congressional Record*, July 13, 1973, at p. 13363.

[12] On Mar. 20, 1975, HUD issued a Request for Proposals to conduct a year-long research effort to appraise congregate housing to determine its effectiveness in meeting resident needs.

[13] Conference Report No. 93-1279, Housing and Community Development Act of 1974, Aug. 12, 1974, at p. 137.

MULTIFAMILY HOUSING: SECTION 236 AND RENT SUPPLEMENT

Section 236, the interest-subsidy program,[14] and the rent supplement program[15] were given a new lease on life in the new Act—but only to a limited degree. Several million dollars in appropriated funds for the Section 236 program were impounded by the Nixon Administration in early January 1973. To date over $100 million remains unspent. The 1974 Act extends the life of Section 236 to June 30, 1976, and authorizes an additional $75 million for Fiscal Year 1975.

The rent supplement program is now merged into Section 236, and authorizes a deep subsidy down to utility costs for up to 20 percent of the units in a Section 236 project.

In the Conference Report, Congress indicated that it expects the Secretary of HUD to use the impounded money for *new* projects, but only when the community has identified its special housing needs and has demonstrated that these needs *cannot be met through the new Section 8 program.*

PROJECTS MUST SUPPORT OLDER AMERICANS ACT

The Secretary of HUD is *required* to consult with the Secretary of Health, Education, and Welfare (HEW) to insure that special projects for the elderly or the handicapped approved under public housing or under Section 8 meet acceptable standards of design, and provide quality services and management consistent with the needs of the tenants.

In addition, these same projects are required to be equipped with such "related facilities" necessary to accommodate the special environmental needs of the elderly or the handicapped, and such projects must be in support of applicable State and local plans for comprehensive services as outlined in legislation such as Title III of the Older Americans Act of 1965.

HOUSING ALLOWANCES

Finally, the 1974 Act directs HUD to continue experiments in the cash assistance program, and authorizes an additional $40 million annually for cash assistance payments. A report with recommendations will be required within eighteen months.

II. THE NEW COMBINATION: SECTION 8 AND SECTION 202—HOW VIABLE?

Then HUD Secretary James T. Lynn, on January 20, 1975, announced that his Department intended to "move ahead" with Section 202. The press release for this announcement also included some disturbing language. While acknowledging that HUD was authorized to make direct loans for rental housing for the elderly and handicapped, the Secretary indicated that the loans "will be available for the construction phase of projects sponsored by non-profit organizations that are assisted under the Section 8 Housing Assistance Payments program."

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[14] Section 236 of the Housing Act of 1968 is an interest-subsidy program for multifamily housing construction. The owner or sponsor pays off a loan as low as 1 percent and the Federal Government pays the interest difference between 1 percent and the interest charged by the financing agency.

[15] Section 101 of the Housing and Urban Development Act of 1965, as amended, provided a program of rent supplements on behalf of needy tenants living in privately owned, privately operated, and privately financed housing. Eligible tenants must pay 25 percent of their income toward the rental rate with the difference between the tenant payment and the monthly rental made up by a rent supplement payment to the project owner.

Permanent financing will be arranged "through the same avenues of FHA-insured or conventional permanent financing as are available for all other Section 8 projects." [16]

CONSTRUCTION VS. PERMANENT FINANCING: THE NEW WRINKLE

The Administration's decision to use Section 202 solely for construction financing could have serious ramifications. In fact, it could mean no program at all.

HUD procedures for implementing a Section 202 program are not now known; regulations are not expected to be published until late April at the earliest. The long delay in setting regulations may be a severe drawback in itself. Normally, after publication, there is a 30-day period for comment before regulations become final. If this procedure is followed, the regulations may not become final until June 1, 1975. The Congress has approved a funding limit of $215 million for Section 202, but that amount is slated for Fiscal Year 1975 which ends on June 30. Consequently, there will be very little time to process enough applications to utilize the full authority.[17]

Experts in the field of housing for the elderly [18] are in full agreement that limiting Section 202 to construction financing without providing an adequate avenue for permanent financing will clearly rule out the participation of the non-profit sponsor. They argue that permanent financing is the major obstacle—non-profits cannot compete with builders and developers on an equal basis and do not have the economic "clout" to convince lending institutions to provide financing.

It is significant to note that Congress recognized this dilemma when it passed the 1974 Housing Act. As written, the law clearly provides for permanent financing for non-profit sponsors through direct loans at the Government interest rate (see above). A total of $215 million has been approved for the first year for just this purpose. Why, then, is HUD choosing to implement the program by restricting the loans to construction financing only?

In a letter to Senator John Sparkman, Chairman of the Subcommittee on Housing and Urban Affairs, James L. Mitchell, Under Secretary of HUD, explained the reasons behind this approach:

> First, it significantly reduces one of the major front-end costs in today's construction market, that of high construction

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[16] A construction loan is a short-term loan (usually 18-24 months) that is advanced by a commercial bank or other lending institution for the purpose of paying for the physical construction of the building (i.e., labor, supplies, fees, etc.). This loan must be repaid shortly after construction is complete. Permanent financing takes the form of a long-term mortgage (usually 20-50 years), secured by the improvements placed on the property. This loan goes into effect beginning with the end of the construction period, and it usually includes conditions requiring that the building be completed and that a certain level of occupancy has been attained. Construction financing is almost always impossible to obtain unless permanent financing commitments have already been secured.

[17] There is some speculation that the regulation procedure will be speeded up. The regulations may be out earlier, as interim rules, to take effect quickly, or with shortened public comment time so the program can begin yet this fiscal year. See *Housing Affairs Letter*, No. 75-13, Mar. 28, 1975, at p. 4.

[18] An Ad Hoc Housing Coalition representing many national organizations for the elderly has kept constant pressure on HUD to implement the Section 202 program. Organizations involved include National Council of Senior Citizens, American Association of Retired Persons- National Retired Teachers Association, American Association of Homes for the Aging, National Council on Aging, B'nai B'rith, American Baptist Churches, Lutheran Housing Coalition, National Caucus of the Black Aged, United Presbyterian Church in the USA, National Rural Housing Coalition, and the National Tenants Organization.

> loan interest rates. We continue to believe that permanent financing can be arranged, using existing Federal agency secondary market support, at interest rates not substantially different from those required on Section 202 loans. However, it is also clear that the cost of financing during the construction phase could be reduced substantially with Section 202 financing. This front-end savings in turn would make possible substantial long term savings in the form of reduced debt service on the permanent loan.
>
> Second, . . . there has been in recent years a severe shortage of loanable funds. This problem probably has been most acute for the type of specialized housing construction in question. Furthermore, it is the construction financing that is most difficult to arrange. The approach we are taking will help assure an uninterrupted flow of construction loan funds for housing for the elderly and handicapped.
>
> Third, use of Section 202 loans for construction opens the way for assisting a larger number of elderly and handicapped individuals than is otherwise possible. The use of construction loans will permit HUD to provide construction financing for more units (subject to the annual authorizations of the Congress) without the need for additional borrowings from the Treasury Department to fund the program.[19]

No one will argue that interest on construction loans can be very high. A program of construction loans at reasonable rates would certainly be helpful; however, of what use is such a program if permanent financing is not available? HUD continues to believe that conventional financing will not be that hard to come by. Non-profit sponsors strongly disagree. Their opinion is supported by the current reactions to the Section 8 program now underway.

Recognizing the very real difficulties of starting up the new Housing Assistance Payments program (Section 8), HUD has already lowered its goal of 400,000 units for Fiscal Year 1975 down to 200,000. If Section 8 does not work, Section 202 will be in deep trouble. In fact, it becomes an impossibility: without the subsidy of Section 8, the 202 program with Government interest rates would only produce rents far above the ability of even middle income elderly to pay.

HUD is saying, in effect, that any non-profit sponsor desiring a Section 202 construction loan, must first obtain permanent financing. The non-profit must acquire its permanent loan through FHA or conventional means *on the same basis* as any builder or developer who is seeking a straight Section 8 project. Unfortunately, even experienced builders and developers are having trouble obtaining financing for Section 8. One housing development director highlighted this problem as follows:

> * * * one of the most debilitating and curious shortcomings remains virtually unaddressed by HUD: evaluations by underwriter and issuer alike have concluded that, given the regulations set forth by HUD to govern implementation of Section 8, *necessary financing almost certainly cannot be obtained.* Echoing the assertion by HUD representatives that

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[19] Letter from Under Secretary of Housing and Urban Development, James L. Mitchell, to Senator John Sparkman, Mar. 19, 1975.

> "Section 8 is not a financing vehicle," Standard & Poor has announced that, because of the regulations, it will decline to award a rating to the bonds local housing authorities may attempt to issue to finance a Section 8 development. At the same time, private financial institutions have warned repeatedly that, for several major reasons (e.g. the 20-year maximum term for housing assistance payments), they do not anticipate providing financing to private developers for Section 8 developments (emphasis in original).[20]

If private developers cannot obtain long-term financing, non-profit sponsors certainly cannot be expected to do any better.

It should be pointed out that using 202 as a construction loan program, per se, is not necessarily a bad idea—so long as permanent financing is readily available as well—through some other workable mechanism. In this manner, the 202 funds could be turned over more rapidly, and more housing for the elderly could be built.

What remains to be seen is how HUD will react to these obvious difficulties. With the end of Fiscal Year 1975 looming very near, there is not much time remaining to put a solid housing program for the elderly into operation.

III. AGED RENTERS AND THE HIGH COST OF ENERGY

The fight for a new construction program for the elderly, specially designed for their needs, is, unfortunately, leading to a program of relief for only a limited number of older Americans of the many who desperately need housing assistance. The high cost of new construction is so great that it is unrealistic to view building new units as a sufficient answer except for a few. To many, especially the renter with no assets, maintaining rent payments has become a grim struggle.

Testimony by HUD officials at a hearing entitled "The Impact of Rising Energy Costs on Older Americans"[21] shed little light on the strain placed on older renters. At that time HUD admitted that their data was "simply inadequate" to provide any meaningful statistics on this issue.

A close look at 1970 Census statistics provides a ready insight into how grim that picture can be.[22]

There are about 3.8 million elderly households (with head 65 or older) who rent. Of this total over 1.7 million households (or 45 percent) pay over 35 percent of their income for rent.

The figures are more startling when only the low income elderly are considered. About 2.2 million aged renters have incomes under $3,000 per year, and almost 1.5 million of this total (or 68 percent) pay over 35 percent of their income for rent.

Close analysis of one-person elderly households reveals much the same picture. More than 2.2 million elderly renters live in one-person households, and of this number almost 1.3 million (or 57 percent) pay over 35 percent of their income for rent, and their median income is only $1,600 per year. One-person elderly renter households with incomes under $3,000 total over 1.6 million, and of that total, over 1.1 million (or *70 percent*) pay over 35 percent of their income for rent.

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[20] Sangster, Robert P., "For Section 8 Housing—New Financing Relationship Between LHA's and State Housing Finance Agencies Proposed." *Journal of Housing*, No. 2, February 1975, at p. 67.

[21] From prepared statement given before the Senate Special Committee on Aging, Sept. 25, 1974.

[22] Housing of Senior Citizens, U.S. Department of Commerce, Social and Economic Statistics Administration, Bureau of the Census, Subject Report HC(7)-2, at p. 16.

Several developments since the 1970 Census have undoubtedly affected the statistics listed above. For example, a number of Social Security increases have been passed by Congress to improve the overall income status of older Americans. However, at the same time the Consumer Price Index has increased over 30 percent, and the housing portion of that index has increased over 32 percent. Inflationary pressures for housing costs have accelerated particularly over the past year as fuel and utility costs have soared in reaction to the energy crisis. For example, gas and electricity costs in New York City have doubled in the past year.

What the Census figures do not show is how many elderly households are paying over 60, over 70, or over 80 percent of their incomes for rent. Testifying before the Subcommittee on Housing for the Elderly last year, Janet Baker, Director of Senior Citizen Activities for the Mayor of East Orange, New Jersey, told the Subcommittee:

> Twenty-five percent of income is supposed to be a good figure to budget for shelter costs. Some of our senior citizens in East Orange are paying 60, 70, some of them more than 100 percent of income for rent and taxes. This means rapid depletion of savings and/or dependence upon relatives.[23]

In short, an estimated 2 million elderly poor are today paying rent in excess of 35 percent of their incomes with little relief on the horizon. Despite these facts, and the continuing pressures of inflation and energy costs, no special program for the elderly, designed for their needs, is emerging from the Department of Housing and Urban Development. Instead, HUD continues to paint a very rosy picture. Speaking of the "general trends" in housing conditions for the elderly, Mrs. Helen Holt, Assistant to the Secretary for Programs for the Elderly and Handicapped at HUD, testified:

> By every available measure of housing conditions, the elderly have experienced significant and substantial improvements in their housing during the last decade.[24]

The Administration's poor response to the housing needs of older Americans is all the more displeasing when one considers . . . that hundreds of thousands of aged persons are today on waiting lists to get into public or other subsidized housing, . . . that hundreds of dedicated, experienced non-profit sponsors have been anxiously waiting to build for needy senior citizens but still have no program with which to work, and, . . . that the supply of available, reasonably-priced rental housing continues to decline as more and more older buildings become condominiums.

Perhaps the Federal response in this important area can best be summarized by two presidential policies. In 1973, after imposing a housing freeze, President Nixon concluded that the housing problem in this country is basically an income problem and, therefore, the solution was to raise incomes. In 1975, President Ford, despite Federal law to the contrary, called for a five percent ceiling on Social Security cost-of-living increases.

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[23] "Adequacy of Federal Response to Housing Needs of Older Americans," Part 12, hearings before the Subcommittee on Housing for the Elderly, East Orange, N.J., Jan. 19, 1974, at p. 831.

[24] See source cited in footnote 19.

FINDINGS AND RECOMMENDATIONS

Notwithstanding the welcome passage of national housing legislation as embodied in the Housing and Community Development Act of 1974, opportunities for housing older persons in reasonably priced standard units remain scanty.

In the field of new construction—even though Congress gave its blessing to the new Section 8 program and the renewed Section 202 program—there continues to be a strong reluctance on the part of HUD to launch a housing program for the elderly. Specially designed housing for the aged continues to be lost in the shuffle of larger, more general policy recommendations; and there is still no national policy for housing America's aged. Unless HUD is willing to implement the Section 202 program in such a way that permanent financing becomes available to nonprofit sponsors, the revisions of the Section 202 program will be of no assistance.

While stressing the need to provide more new units specially designed for the elderly, the committee also recognizes the importance of assisting those elderly who are paying far too much of their incomes for shelter in existing housing. Many of these persons would gladly remain where they are if assistance were available. Housing allowances, or direct cash assistance, should be made available in these cases as soon as possible.

To relieve the growing burden of paying for shelter of all kinds for the elderly, the committee recommends that:

(1) A national policy for housing for the elderly be established.

(2) An overall minimum of 120,000 new units for the elderly be approved on an annual basis.

(3) An Assistant Secretary for Housing for the Elderly be established at HUD.

(4) Special programs, such as "intermediate" housing and "congregate" housing, be encouraged to provide living arrangements that are alternatives to institutional care.

(5) National legislation be passed encouraging the States to establish "circuit breaker" programs of tax relief for low-income elderly homeowners and renters.

(6) New attention should be directed at opportunities for rehabilitation.

In addition, and specifically with reference to the Section 202 program, as amended by the 93rd Congress, the committee recommends that:

(1) HUD implement 202, as Congress intended, as a direct loan program for permanent financing, not construction financing.

(2) A special "set aside" of Section 8 funding be made available for non-profit sponsors at the Regional level, and that the "Invitation to Bid" procedure now required under Section 8 regulations be eliminated for Section 202.

(3) A "one window" procedure for simultaneous filing of Section 202, Section 8, and any available refinancing mechanism be made available at the Regional level.

(4) The Section 202/Section 8 program be administered at the HUD Regional Office level by a separate specialized staff whose sole responsibility is this program.

CHAPTER VII

IMPROVING THE OLDER AMERICANS ACT

Decisions are due in 1975 on the Older Americans Act, originally enacted 10 years ago to provide, in the words of the Congress:

> Assistance in the development of new or improved programs to help older persons through grants to the States for community planning and services and for training, through research, development, or training project grants, and to establish within the Department of Health, Education, and Welfare, an operating agency to be designated as the "Administration on Aging.[1]"

Technically, the Act is to expire on June 30 of this year; but there seems no likelihood of this. The House of Representatives has already overwhelmingly passed an extension. The Administration has advanced a far less ambitious bill. And the Senate is nearing final action on what will probably be a measure combining features of several bills before its Committee on Labor and Public Welfare.

Congressional readiness to act favorably on an extension is based partially upon a deeprooted conviction that steady growth of programs under the Older Americans Act must be continued.

That conviction was expressed during House deliberations on the extension bill by Representative John Brademas, major sponsor of the legislation and Chairman of the Subcommittee which developed it:

> . . . witnesses before the Select Education Subcommittee, including representatives of a wide variety of organizations serving the elderly, were unanimous in telling us that the time had come significantly to expand the programs supported under the Older Americans Act. The 4-year bill before us . . . does allow for that expansion.[2]

Senator Frank Church, Chairman of the Senate Special Committee on Aging, made similar comments when he introduced his Older Americans Act Amendments of 1975:

> Ten years of experience under the Older Americans Act have amply demonstrated its value and worth for the Nation's elderly. The legislation that we introduce today is designed to build upon these solid achievements.[3]

Senator Harrison A. Williams, Chairman of the Senate Committee on Labor and Public Welfare and a sponsor with Senator Church of the extension legislation, said on the same occasion that the bill would stimulate planning and action in developing a national policy on social services for the elderly. Furthermore, it would also help achieve a major recommendation of the 1971 White House Conference on Aging:

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[1] Public Law 89-73 (July 14, 1965). The Older Americans Act was later amended by: Public Law 90-42 (July 1, 1967), Public Law 91-69 (Sept. 17, 1969), Public Law 92-258 (Mar. 22, 1972), Public Law 93-29 (May 3, 1973), and Public Law 93-351 (July 12, 1974).

[2] P. H. 2479, *Congressional Record*, Apr. 8, 1975.

[3] P. S. 5876, *Congressional Record*, Apr. 14, 1975.

> Older Americans should be served by an integrated system, sharing equitably with other age groups those facilities, programs, and services suitable and appropriate to the needs of the general population, but they should also have the benefit of specialized facilities, programs, and services based on their distinctive needs.

Such confidence in the Older Americans Act was forthcoming despite considerations which clearly will receive sustained Congressional attention during its next few critical years of the developments. Those considerations are:

- —The Administration reluctance to seek funding levels which, in the eyes of the Congress, are adequate for the tasks assigned to the Administration on Aging, as well as proposed rescissions which would have taken away vital support for programs in a vulnerable stage of development. (See Chapter I for details on Administration funding policy.)
- —Deeprooted questions about area agencies on aging, the units established under the 1973 amendments for implementing a new strategy of service delivery. One major question is: how well will AAA's work with state agencies on aging?
- —Concern about funding problems facing the Title VII Nutrition for the Elderly Program, described by Senator Thomas F. Eagleton, Chairman of the Senate Subcommittee on Aging, as "one of the most popular and most successful Federal programs I have ever seen."[4]

I. WHAT THE OLDER AMERICANS ACT HAS ACCOMPLISHED[5]

Often during Congressional discussion of the Older Americans Act, witnesses for the Administration and members of the Congress have pointed to the same list of achievements under that Act.

Among the major items on their lists:

- —Every State and virtually every territory now has a state or territorial office on aging.
- —Area agencies have been established in 412 locales containing 70 per cent of Americans above age 60.
- —Under title VII, nearly 220,000 older adults are receiving one hot, nutritious meal daily at more than 4,000 sites.
- —Thirty-seven career training programs have enrolled 4,600 students in courses related to aging. More than 6,300 persons received short-term training in fiscal year 1974.
- —A national clearinghouse on aging has been established to collect and disseminate information about older people and their needs.
- —The AoA is also authorized to fund model projects. (In 1974, $12 million was awarded to State agencies to conduct statewide model

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[4] In opening statement at start of hearings on legislation to extend the Older Americans Act, Apr. 16, 1975.

[5] For a detailed report by the Administration on Aging on its activities during 1974, see Appendix One.

projects, but during fiscal year 1975, only $5 million was requested to support 40 projects) and research and demonstration projects (119 new and continuing projects received financial assistance in fiscal year 1974.)

—Related achievements under other Federal agencies include the participation of 130,000 persons in the Retired Senior Volunteer Program, or RSVP; and employment of 3,450 persons of age 55 and up in the Title IX community services employment programs. (See Chapter X for additional information on Volunteer and Community Service for the elderly.)

Mere listing of numbers, however, does not tell the full story of the impact that the Older Americans Act is having and can have. The existence of state units on aging is having a marked effect on decisions made by state legislators. The advent of area agencies on aging is certain to produce more constructive concern and action on aging by county and local government than has been the case in the past. The development of what U.S. Commissioner on Aging Arthur Flemming[6] calls a "network" consisting of the Administration, the State offices on aging, 412 area agencies on aging, and 665 nutrition projects is well under way. Much depends upon the future success or failure of this process.

II. WHAT THE NEW LEGISLATION WOULD DO

Administration policy on extension of the Older Americans Act was expressed in Senate Bill 599,[7] which calls for:

First, authorizations for most titles would be extended for 2 years, to June 30, 1977, thus coinciding with Title VII's period of authority.

Second, Title V and Section 309—authorizing grants for purchase, renovation, and initial staffing of senior centers and grants for transportation projects—would be permitted to expire because of Administration belief that "they are duplicative of existing authorities available to the Departments of Housing and Urban Development and Transportation and had never been funded."[8]

Major bills advanced in both Houses of Congress, however, reject the Administration recommendations and call for new directions in the Older Americans Act.

A. The House-Passed Bill: H.R. 3922

Under the chairmanship of Representative Brademas, the Subcommittee of Select Education developed a bill calling for overall authorizations of nearly $2.6 billion for a 4-year extension, through fiscal year 1979.

It also:[9]

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[6] In testimony Apr. 16 before the Senate Subcommittee on Aging.

[7] Introduced at Administration request by Senator J. Glenn Beall, Jr.; see p. S. 1606, *Congressional Record*, Vol. 121, No. 17, Friday, February 7, 1975.

[8] From testimony by Stanley B. Thomas, Jr., H.E.W. Assistant Secretary for Human Development, before the Senate Subcommittee on Aging, Apr. 16, 1975.

[9] For additional details on the provisions and reasons for including them, see House Report 94-67, "Older Americans Amendments of 1975," submitted Mar. 14, 1975, by Representative Carl Perkins, Chairman of the House Committee on Education and Legislation. For details of the bill as amended in Floor Action, see pp. H2472–H2481, *Congressional Record*, Apr. 8, 1975.

Extends the program of grants to states for community services for 4 additional years, through fiscal year 1979 and provides for additional distribution of certain important commodities.

Extends the Older American Community Service Employment Act for 4 additional years through fiscal year 1979.

Extends the National Older American Service programs, including the Retired Senior Volunteer Program (RSVP), the Foster Grandparent Program, and the Senior Companion Program, as well as other Older American Community Service programs for 3 additional years, through fiscal year 1979.

Creates a new Special Service Program for the elderly which would provide greater emphasis on homemaker and other home services, counseling assistance, residential repairs and renovations and transportation for the elderly—at least 20 percent of funds provided to carry out the program of grants to states for community services shall be used for these purposes.

Provides for direct funding for service programs for Indian tribes.

Prohibits discrimination in Federal programs or activities on the basis of age.

B. THE OMNIBUS SENATE BILL: S. 1426 [10]

As introduced by Senators Church and Williams on April 14, S. 1426 adopts major provisions of H.R. 3922, but adapts others and introduces several new features.

Other sponsors of the Older Americans Amendments include Senators Tunney, Chiles, Stone, Clark, Pell, Hartke, Randolph, Kennedy, Burdick, Humphrey, and Ribicoff.

Instead of a 4-year extension, it calls for a two-year continuation but at higher authorization levels for those two years ($812 million compared with $743 million in the House-passed bill for fiscal years 1976 and 1977).

Among the other major changes in S. 1426:

The Model Projects program (section 308) would be amended to give priority attention to improving service delivery for the rural elderly.

Federal funds would be authorized under Title VII to assist the States in paying part of the costs of administering the nutrition program. This measure would not, however, result in any decrease in meals served to older Americans because there would be a 10-percent increase in the Title VII authorizations (from $200 million to $220 million for fiscal 1976 and from $250 million to $275 million for fiscal 1977) to provide for State administrative costs.

The new Title XX (Social Services) of the Social Security Act would be amended to require State plans to include a description concerning how the State plan is coordinated with Titles III (State and Community Programs on Aging), VII (Nutrition), VIII (a proposed Special Services Program for the Elderly) and Title IX (National Senior Service Corps) of the Older Americans Act.

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[10] Senator Eagleton introduced another bill, S. 1425, on Apr. 14. He commented (p. S.5875, *Congressional Record*, Apr. 14): "The bill I am introducing would extend a number of programs authorized by the Older Americans Act of 1965 for an additional two fiscal years beyond June 30, the date on which these programs would otherwise expire . . . The purpose of the simple bill I am offering is so that the subcommittee (on aging) will have before it legislation in addition to that passed earlier this week by the House, H.R. 3922, and that introduced on behalf of the administration by Senator Beall, S.599. It is my understanding that Senators Church and Williams are also preparing a bill on this subject for introduction prior to our hearings."

Legal Service Needs Recognized: Senator Tunney introduced a Legal Counseling Assistance Act (S. 1422) which was the product of a hearing conducted by the Committee on Aging and the Judiciary Subcommittee on Representation of Citizen Interests on "Improving Legal Representation for Older Americans." [11]

S. 1422 would amend Title IV of the Older Americans Act to authorize Federal funds to (1) train lawyers, lay advocates, and paraprofessionals about the special legal problems confronting the aged; (2) develop law school curricula and clinical education programs responsive to the problems and needs of the elderly, and (3) provide legal counseling assistance for older Americans.

A similar provision was incorporated in the proposed Title VIII Special Service Programs for the Elderly in the House-passed bill (H.R. 3922) and the omnibus Senate measure (S. 1426).

III. AREA AGENCIES ON AGING: SECURE CORNERSTONE?

Congress, when it acted upon the Older Americans Act of 1973, accepted in principle a new Administration strategy for the delivery of services.[12]

Instead of relying primarily on small, one-community programs, the Administration on Aging would encourage development of new regional units called area agencies on aging.

As has been mentioned, 412 such agencies have been established in less than 2 years. Their advent could mark the beginning of a fresh and challenging new approach toward meeting many major needs of the elderly.

But, at this early date, the returns are not yet in on AAA's.

What may be the prevailing Congressional attitude toward them was summed up by Senator Eagleton in his opening statement at the April 16 hearing on extending the older Americans Act:

> In order to meet our legislative review responsibilities, this Subcommittee, in conjunction with the Special Committee on Aging, has asked the General Accounting Office to conduct a wide-ranging survey of the performance of state area agencies on aging under Title III. The final results on this survey are expected around the end of this month, and the staff has already been given an oral briefing.
>
> From what we have learned so far from the GAO study and from other sources, it appears that there may be some problems with the operation of the state and local grant program under Title III; however, our information is very sketchy since most of the area agencies on aging have been in existence

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[11] "Improving Legal Representation for Older Americans." Joint hearings before the U.S. Special Committee on Aging and the Subcommittee on Representation of Citizen Interests of the Judiciary Committee, Los Angeles, Calif., 93d Cong., 2d sess., June 14, 1974.

[12] See Chapter VII, *Developments in Aging: 1973 and January–March 1974*, annual report of the Senate Special Committee on Aging, May 13, 1974, for additional background on the 1973 Amendments and early reaction to AAA's.

> for less than a year. It would be premature to seek to arrive at any final conclusions regarding the area agency strategy until more information is available. For this reason, I am hopeful that the Subcommittee will not make any drastic revisions in the organizational structure established by Title III at this time.

Senator Eagleton's call for a suspension of judgment about AAA performance was similar to the sense of the House of Representatives as expressed in H.R. 3922. Well aware of problems which are emerging as AAA's take form and enlarge their spheres of activity, members of the Congress are nevertheless determined to give the AAA strategy a fair test, and an adequate one.

A. BACKGROUND: WHAT THE AoA WANTS FROM AAA'S

A succinct description of AAA objectives was provided by Administration on Aging guidelines issued on October 11, 1973. They said in part:

> It is the purpose of this title to encourage and assist State and local agencies to concentrate resources in order to develop greater capacity and foster the development of comprehensive and coordinated service systems to serve older persons by entering into new cooperative arrangements with each other and with providers of social services for planning for the provision of and providing, social services and where necessary to reorganize or reassign functions in order to—
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> (1) secure and maintain maximum independence and dignity in a home environment for older persons capable of self-care with appropriate supportive services; and
>
> (2) remove individual and social barriers to economic and personal independence for older persons.[13]

Simply stated, the Title III strategy is based on the assumption that there is a reservoir of resources and services available in a local community. It is the role of the area agency on aging to attempt to refocus these resources and services on behalf of the elderly population.

B. EMERGING PROBLEMS AND QUESTIONS

The primary responsibility of the area agency on aging is the development and implementation of a plan of comprehensive and coordinated services for older persons. How all this can be done by a new organization with limited resources and questionable political leverage is one of the important questions about the title III strategy.

In a paper presented at the 27th Annual Scientific Meeting of the Gerontological Society in Portland, Oreg., last October consultant B. J. Curry Spitler gave this estimate of the situation:

> Coordination and linkage is necessary, as is information and referral, but these activities are not substitutes for service. While the terms coordination, linkage and information are relatively nonthreatening to other organizations, their value

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[13] *Federal Register*, Thursday, Oct. 11, 1973, vol. 38, No. 196, Title 45—Public Welfare Chapter IX—Administration on Aging, Department of Health, Education and Welfare Part 903 Grants for State and Community Programs on Aging.

> to the development of truly comprehensive service system is being questioned by local service organizations who tend to perceive the new AAA's as an upstart organization diverting funds that could otherwise be used by them to provide real service. Planning, especially social planning, seems to raise questions of who is planning what, with whose resources, and as funds for service continue to dwindle, service providers have justification for perceiving the AAA's as usurper of service dollars.

An editorial entitled "The Area Agency on Aging: Instant Planning" appeared in the February 1975 issue of *The Gerontologist*, and raised still other considerations:

> The push for instant planning without key planning tools . . . is fraught with danger. The planner himself is a major planning tool. To what extent have our educators been able to develop gerontological planners, those who have a basic planning background rounded by gerontological knowledge or a gerontological background rounded with planning knowledge concepts? The instant gerontological planner is not available, except in rare and unusual instances. Unless the state agency on aging has such a staff person located in a positional hierarchy of influence within the state body, area agencies on aging will fall prey to the big push for immediate results regardless of long time consequences instead of needed longer time deadline if one is to plan properly. Immediate results may be interpreted within the time frame of upwards of 12 months.

The editorial further stated:

> The movement toward integration of local aging services will be highly problematical, at the best, if the only tool of the AAA is that of control of minimal project money. Involvement of all segments will not be enhanced by the latter. What would be a prime enhancing factor are sensitized aging planners who understand planning, comprehend gerontology, are cognizant of local strengths/weaknesses/people/organizations and are able to mold these into an effective integrative agency to improve the quantitative and qualitative dimensions of living in the oldest of years.

Success or failure of AAA's will depend to a large degree on the skill and tact of AAA personnel in the field. As B. J. Spitler put it in her paper:

> The survival of the AAA may, in large part, depend upon its ability to change the communities' perception of it from a usurper of service funds to a helpful organization that fosters public awareness, provides useful information, and strengthens existing programs, as well as develops new services.

Solid research on the function of the area agency on aging is just beginning to appear, but a number of important trends can be identified through preliminary studies and at a meeting of AAA's and State agencies called by the Administration on Aging in Washington, D.C., in December 1974.

(1) Some State units on aging and area agencies on aging are in conflict. Until the 1973 amendments, State agencies had both a planning and service function. They were involved in the local level with programs and responsible for implementing the Act on a day-to-day basis. Now, day-to-day monitoring of many local programs has shifted to AAA's.

(2) Many AAA directors say they have been overwhelmed by directives, guidelines and other program requirements from the Administration on Aging. In addition the State unit on aging may make other demands. Given the small number of employees that are available to most area agencies these reporting requirements are regarded as unrealistic.

A recently completed survey by the Social Policy Laboratory of the University of Southern California Gerontology Center said:

> By far the most frequently mentioned problem, usually stated with considerable vigor, regarded the large quantity of mandates and regulations in relation to the small amount of funds being provided by the Administration on Aging.

The report further asserts:

> Not surprisingly, most of the negative comments concerned too many forms or inappropriate forms which were required for recording and reporting program performance and related expenditures. Some of these requirements seem to originate from the federal level, such as separate incompatible forms for reporting Title III and Title VII activities. Other requirements which constituted barriers seem to originate at the state level, such as reporting to the state agency every long distance phone call and presenting records of all xeroxing done at the AAA.[14]

THE GAO SURVEY

The General Accounting Office survey to which Senator Eagleton referred was requested by three units of the Congress [15] in order to provide at least an early, preliminary view of the AAA's in operation. The GAO report, at this writing, has not yet been released, but it is due for publication by mid-May.

Unlike other GAO studies—many of which are based solely upon audits of records—the AAA inquiry entailed extensive interviews at 28 AAA's and at state agencies on aging in 17 states.[16]

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[14] A study of Funding Regulations, Program Agreements and Monitoring Procedures Affecting the Implementation of Title III of the Older Americans Act Progress Report No. 1 "Findings of the Telephone Survey of 103 Area Agencies on Aging. Social Policy Laboratory Gerontology Center, University of Southern California Feb. 15, 1975.

[15] The U.S. Senate Special Committee on Aging, the Subcommittee on Aging of the Senate Committee on Labor and Public Welfare, and the Subcommittee on Select Education of the House Committee on Education and Labor.

[16] Area Agencies on Aging visited were: Oaklyn, N.J.; Doylestown, Pa.; Honesdale, Pa.; Pittsburgh, Pa.; Atlanta, Ga.; Gainesville, Ga.; Rock Hill, S.C.; Greenville, S.C.; Miami, Fla.; Winter Park, Fla.; Chicago, Ill.; Mt. Carmel, Ill.; St. Paul, Minn.; Duluth, Minn.; Cleveland, Ohio; Columbus, Ohio; Vincennes, Ind.; Terre Haute, Ind.; Escanaba, Mich.; Flint, Mich.; Albuquerque, N. Mex.; Pueblo, Colo.; Durango, Colo.; Tucson, Ariz.; Sacramento, Calif.; San Diego, Calif.; Los Angeles, Calif.; and Pocatello, Idaho.

State Agencies on Aging visited were: Rhode Island; Massachusetts—work limited to determining the effects of the AAA concept on an existing sub-State network for providing services to the elderly; New Jersey; Pennsylvania; Georgia; South Carolina; Florida;

Many of the problems described earlier in this chapter were recounted to the GAO interviewers. But there were also heartening instances of effective, imaginative, and cooperative efforts to make the new strategy work. The same is true of letters solicited by Senator Church, Chairman of the Senate Committee on Aging, from agencies which were not visited by the GAO personnel. For example:

The Areawide Council on Aging of Broward County, Fort Lauderdale, Fla., reported:

> The Executive Director and staff members of the Areawide Council on Aging speak about the Areawide Program to the Broward County Commission, United Way, and city councils in Broward County, and request matching funds for programs. To date, $94,415.00 in matching funds for 1975 programs have been contributed to Areawide through these efforts. A Fair Share Funding Table has been developed by Areawide giving the number of elderly in each city and the unincorporated areas, and assessing each city and the county for so much money depending upon the number of elderly in the county and respective cities.

The Cape May County, N.J., Office on Aging stated:

> Recognizing the needs of the elderly in Cape May County, the Area Agency on Aging developed a plan which was approved at a public hearing. This plan includes the establishment of four new services for older people. Homemakers-home health aides will be given a grant to expand their services to include those older people with a minimal income who do not qualify for any existing programs. Legal Services will be expanded to include legal services specifically for the elderly. An Escort Service will be initiated, and finally, Counselling Services for the elderly will be provided. Assistance was given by this Office to each of the grantees in preparing their project's preliminary application and budget.

The Lancaster County, Pa., Office of Aging reported:

> Another striking success that I have noted through the AAA is emphasis on coordination with existing resources. Lancaster County has over 160 different agencies. Most of these agencies are privately funded and therefore tend to have a service limitation. By having monies funded through the AAA, I have been able to assist agencies in expanding their service to meet the needs of senior citizens. In determining where a service would be most appropriate I have also been able to assist agencies in coordinating their efforts rather than sustaining service duplication.

The Senior Citizens Affairs Office of the County of San Diego, Calif., described an innovative program to serve that community's elderly:

> A Home Helps Program, personal, in-home supportive services to the dysfunctional and marginally disabled old

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Illinois; Indiana; Minnesota; Ohio; Michigan; New Mexico; Colorado; Arizona; California; and Idaho.

Department of Health, Education, and Welfare Regional Offices visited were: Region I, Boston, Mass.; Region II, New York, N.Y.; Region III, Philadelphia, Pa.; Region IV, Atlanta, Ga.; Region V, Chicago, Ill.; Region VI, Dallas, Tex.; Region VIII, Denver, Colo.; Region IX, San Francisco, Calif.; and Region X, Seattle, Wash.

> people will begin in early 1975, through subcontracts with several neighborhood organizations whose goal it is to maintain older people in the community for as long as possible and feasible. The Area Agency has also utilized its Area Plan to obtain Title VII nutrition funds and has subcontracted these services in nine (9) Target Areas. The experience of developing nutrition programs through community organizations and groups with the Area Agency as catalyst for program development has been valuable in several respects. The nutrition sites are perceived by the community as "service centers" around which other community resources can be tapped and as identifiable hubs of information and socialization. Perhaps most important, the communities involved have a real sense of investment and continuing commitment to these programs, whether Title VII remains a viable funding source or not.

It is quite clear that the AAA strategy requires extensive testing before final judgments are made, and it is equally clear that emerging problems are formidable and attention-getting. But final evaluation should also include the success stories that are already beginning to emerge; they are part of a process which will be slow, occasionally strained and even bitter, but well worth the patience, skill, and receptiveness not only of agency directors but those with whom they work and those they serve.

IV. NEW DEVELOPMENTS AT THE STATE LEVEL

Like the Administration on Aging at the Federal level, state units on aging are intended to be focal points for action on behalf of older Americans. The original Older Americans Act envisioned a close Federal-State relationship, and amendments issued since then in many ways have buttressed the state agencies. Despite some concern about possible erosion of the importance of state units because of the establishment of hundreds of AAA's, there seems to be a clear and growing need for strong agencies on aging at the state level.

Aware of new and interesting achievements at the state level, Committee on Aging Chairman Frank Church asked late in 1973 for state agencies to report to him on positive actions taken to strengthen the state role in meeting the needs of the elderly.

The response was so informative and extensive that the Senator asked former AoA Commissioner William E. Bechill to analyze the replies. The result was a report[17] which provided details on state trends regarded by Mr. Bechill as significant and encouraging. He described:

—Increases in both quantity and quality of employees working with state units.

—A reduction of the focus on state units from project orientation to program development.

—An increased influence and prestige of some state units, including increased funding and significantly higher awareness by the public of the needs of older persons.

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[17] *Developments and Trends in State Programs and Services for the Elderly*, a report by the Senate Special Committee on Aging, November 1974.

—Of particular significance, the establishment of separate State Departments on aging in Connecticut, Massachusetts, and Illinois.

—Another major trend was the number of States which have established the State agency on aging as part of the Office of the Governor, or have elevated the existing State agency on aging to the stature of an operating office or division within a major department of State government.

At the time of the study 20 States reported that they were organized as independent State commission of offices on aging.

DETAILS ON STATE DEPARTMENTS

The Connecticut Department, established in 1969, has broad responsibilities which include the administering agency for Title III and Title VII programs of the Older Americans Act. In addition, Connecticut has an office of preretirement education and an expanded meals-on-wheels program.

In 1973 the Massachusetts legislature mandated that the department of elder affairs, effective July 1, 1974, "Be the principal agency of the Commonwealth to mobilize the human, physical and financial resources available to plan, develop and implement innovative programs to insure the dignity and independence of older persons." The department is also responsible for a yearly study of the quality of care and social services provided for nursing home patients.

The Illinois Act on Aging, passed in 1973, said the purpose of the Department is "to provide a comprehensive and coordinated service system for the State's aging population."

One interesting aspect of the Illinois act is the definition of aged as persons 55 years of age or older, persons nearing the age of 55 for whom opportunities for employment and participation in community life are unavailable.

THE NEED FOR SUSTAINED DIALOGUE

Impressed as Mr. Bechill was with positive evidence of improvement in state agencies, he noted that certain issues should receive sustained attention, perhaps even serving as the basis for future dialogue between interested administrative and legislative leadership at both the Federal and State levels of government regarding future public policy directions in programs on aging.

These issues, each of which was discussed in more detail by Mr. Bechill, are:

1. To what extent should national policy in aging rely on the States, and in particular, State agencies on aging for the development of a comprehensive program of social services for the entire older population?

2. In the short run, what additional actions need to be taken by the Federal Government to strengthen further the functioning of existing State programs on aging?

3. Should it be assumed now, as is largely the case, that the major funds for most programs and services for older people will continue to be made available through the existing functional departments of government. If so, what can be done through both

future Federal and State policy to assure that the elderly as a group do not have their needs overlooked in the administration and operation of functional programs?

4. What can be done to assure that there is a current and comprehensive assessment of the actual fiscal commitments of all levels of government, local, State, and Federal, to serving older people and an assessment of the impact of such dollars on improving the actual living conditions and opportunities for the elderly?

5. What steps should be taken, possibly on a joint basis between the Federal Government, the Council of State Governments, and individual State legislature to encourage the establishment of additional joint or select committees on aging as a part of the structure of State legislative bodies?

6. In such critical areas for the elderly as housing, long-term care, and mental health services, does the Federal role need to dramatically change to reduce some of the pressing needs for appropriate facilities and services in these areas for older people?

7. The new Older Americans Act title III program ultimately will see the establishment of 600 area agencies on aging across the Nation. Authorized under Federal law, the area agencies on aging represent a new organizational dimension that can be expected, in time, to influence current Federal-State relationships in programs for the aging. What steps should be taken in future Federal policy to strengthen both ability and capacity of State and area agencies on aging as well as clarify and reconcile any ambiguities and conflicts about their actual roles in developing comprehensive and coordinated systems of social services for the elderly?

V. TITLE VII—NUTRITION PROGRAM FOR THE ELDERLY

Title VII of the Older Americans Act, the Nutrition Program for the Elderly, was extended last year by the Congress for three more years at increased authorization levels of $150 million for fiscal 1975, $200 million for fiscal 1976, and $250 million for fiscal 1977.[18] At hearings held by the Senate Subcommittee on Aging regarding the extension of the program, enthusiastic reports were heard about the worth and effectiveness of the program.

Dr. Louise Gerrard, executive director of the West Virginia Commission on Aging, said:

> The elders of the community are seen in happy situations, having meals together, enjoying good fellowship, entertaining and being entertained. The economy gets a needed boost when food is purchased in local stores, and men and women from the area are hired as drivers, cooks, outreach workers and site managers. Although most of our Title VII employees receive only the minimum wage, the jobs are welcome and much sought after.[19]

Other witnesses praised the program, but expressed great concern about the struggle to provide services on limited budgets in the face of inflation.

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[18] Public Law 93–351 signed into law July 12, 1974.

[19] In testimony before the Subcommittee on Aging of the Labor and Public Welfare Committee, "Extension of Nutrition Programs for the Elderly, 1974," May 22, 1974.

Rodney Leonard, executive director of the Community Nutrition Institute, said that some projects were already over-extended. He added:

> Unless additional funds are made available, they are going to have to cut down participation. They are going to be faced with the problem of how do you reduce or tell people they cannot participate?[20]

Food costs have escalated nearly one-third over the past two years.[21] Title VII nutrition projects had to develop innovative and sometimes desperate methods in order to attempt to serve the number of elderly who want to participate.

As waiting lists grew longer, project directors tried to decide who was the most in need. Pseudo means tests were attempted; a ticket system allowing certain persons to attend meals on certain days of the week was introduced; in States the number of projects was reduced; supportive services and home-delivered meals were curtailed; at some sites, the elderly were served on a first-come, first-serve basis; and in some cases therapeutic diets were terminated. Despite such methods, the number of potential elderly recipients of the Title VII meals increased substantially as the year progressed. In a survey of Title VII projects in the early winter of 1974, the National Association of State Units on Aging showed 178,000 elderly were being served. The survey, as shown below, also depicted the States' pleas for an additional funding to combat the inflationary standards the programs must operate, and the number of people on waiting lists stood at 116,583.

SURVEY OF NATIONAL STATE UNITS ON AGING

State (1)	Title VII funding (2)	Number of projects (3)	Average daily participation (4)	Persons on waiting list (5)	Projects unable to get commodities (6)	Additional funding needed in fiscal year 1975 (7)	Funding needed for new expanded projects (8)
Alabama	$1, 565, 052	6	4, 200	6, 000–7, 000	6	$212, 000	$4, 500, 000
Arkansas	1, 098, 667	9	1, 938	1, 500	5	177, 585	3, 298, 459
California	8, 454, 000	52	17, 000	8, 724	([1])	1, 500, 000	12, 500, 000
Colorado	915, 222	5	1, 852	425	5	195, 000	950, 000
Connecticut	1, 358, 465	11	1, 200	1, 200	7	543, 386	1, [illegible]68, 000
Delaware	493, 000	4	1, 150	200	2	100, 000	250, 000
Florida	4, 704, 547	19	9, 300	2, 497	17	1, 411, 364	4, 000, 000
Idaho	493, 000	7	1, 1400	300	7	47, 000	815, 000
Illinois	5, 023, 818	30	10, 000	2, 500	([2])	750, 000	3, 500, 000
Iowa	1, 521, 231	12	4, 200	4, 000–5, 000	8	250, 000	1, 980, 000
Kentucky	1, 547, 256	9	3, 866	600	7	250, 000	800, 000
Louisiana	1, 471, 149	9	2, 978	2, 300	9	147, 000	1, 029, [illegible]
Maine	516, 467	5	2, 564	14, 000	([1])	258, 233	1, 033, 000
Maryland	1, 471, 149	13	3, 500	1, 043	([1])	220, 800	614, 423
Michigan	3, 518, 237	31	8, 100	18, 490	26	300, 000	2, 120, 000
Minnesota	1, 810, 695	17	4, 300	1, 100	17	225, 000	1, 322, 040
Mississippi	1, 042, 325	9	2, 419	1, 644	9	208, 465	1, 050, 000
Missouri	2, 504, 084	9	7, 800	6, 000	6	1, 205, 852	5, 505, 852
Montana	493, 000	5	900	1, 000	([1])	200, 000	1, 300, 000
Nevada	493, 000	10	1, 282	850	([1])	123, 500	507, 000
New Hampshire	493, 000	6	1, 425	2, 850	1	98, 000	970, 000
New Jersey	3, 308, 520	23	5, 786	2, 500		830, 000	51, 897, 000
New Mexico	509, 376	6	1, 500	10, 000	1	509, 376	609, 376
New York	8, 955, 000	47	20, 000	([3])	([4])	5, 000, 000	15, 000, 000
North Carolina	2, 050, 219	24	4, 520	1, 100	6	507, 000	915, 000
North Dakota	493, 000	6	945	N/A		200, 000	450, 000
Ohio	4, 731, 013	18	8, 400	8, 000	1	600, 000	10, 000, 000

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[20] In testimony before the Subcommittee on Aging of the Labor and Public Welfare Committee, "Extension of Nutrition Programs for the Elderly, 1974," May 22, 1974.

[21] From Bureau of Labor Statistics.

SURVEY OF NATIONAL STATE UNITS ON AGING—Continued

State	Title VII funding	Number of projects	Average daily participation	Persons on waiting list	Projects unable to get commodities	Additional funding needed in fiscal year 1975	Funding needed for new expanded projects
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Oklahoma	$1, 347, 116	5	3, 400	257	5	$100, 000	$1, 250, 000
Oregon	1, 067, 365	5	3, 000	(1)		213, 473	1, 317, 365
Rhode Island	493, 000	6	925	1, 200		250, 000	5, 000, 000
South Dakota	493, 000	8	1, 000	(1)	4	131, 077	750, 000
Utah	493, 000	3	1, 000	(1)	3	246, 000	1, 616, 000
Washington	1, 505, 580	14	2, 580	2, 500	14	225, 000	670, 000
Virginia	1, 787, 875	19	3, 000	500	19	531, 510	650, 000
West Virginia	904, 600	12	2, 000	400	(1)	120, 000	500, 000
Wisconsin	2, 137, 862	16	5, 500	4, 000	15	250, 679	2, 955, 579
Wyoming	493, 000	4	700	50	4	100, 000	500, 000
Massachusetts	2, 825, 000	18	6, 019	2, 000	16	400, 000	5, 000, 000
Texas	4, 760, 000	16	11, 000	5, 000	15	960, 000	2, 080, 000
Hawaii	493, 000	4	1, 440	88	0	205, 960	2, 459, 304
Washington, D.C.	493, 000	5	1, 340	365	(4)	70, 000	200, 000
Total 41 States	80, 367, 990	537	178, 169	116, 583	235	19, 873, 224	153, 133, 203

[1] See note.
[2] Not available.
[3] In hundreds.
[4] Almost all.

A. The "History" of Title VII Funding

Funding for Title VII went through a complex process in 1974 culminating in the supplemental appropriations bill for fiscal year 1975 [22] through which the Senate and House of Representatives requested and agreed upon a $125 million appropriations for Title VII for fiscal year 1975. This was an increase over the Administration's budget request of $99.6 million. In addition, the conferees directed the Department of Health, Education and Welfare to "utilize carryover funds to build the program operating level for the nutrition program authorized by Title VII of the Older Americans Act to at least $150,000,000 for fiscal year 1975." [23] This action came as a result of the erratic history of Title VII. Fiscal year 1973 was the first year of Title VII but funds were not released until fiscal year 1974.[24] Subsequently, funds have been carried over to each succeeding fiscal year since that time. Therefore, in fiscal year 1975, the program would be operating on the fiscal year 1974 funding level of $99.6 million. The program's obvious need for increased appropriations to combat the high costs of food, materials, and fuel prompted the conferees to direct the Department of Health, Education, and Welfare to make use of a portion of the fiscal year 1975 funds so that when added to the carried over fiscal year 1974 funds of $99.6 million the program would be operating on a level of at least $150 million. Since the cost of one meal under the Title VII program has increased from approximately $1.54 (at the beginning of the program) to about the current cost of $2.16.[25] The increased appropriation may allow the projects to at least serve those on their waiting lists.

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[22] Public Law 93–554 signed into law on Dec. 27, 1974.

[23] Conference report 93–1503, ordered to be printed on Nov. 26, 1974 to accompany H.R. 16900.

[24] Fiscal year 1973 supplemental appropriations bill, Public Law 93–50, was not signed into law until July 1, 1973.

[25] Estimates of the Administration on Aging, Department of Health, Education, and Welfare.

VI. ADDITIONAL ISSUES FACING THE AoA

Administration on Aging Commissioner Arthur Flemming has been frank to admit that the AoA—just one agency among many at the Department of Health, Education, and Welfare—faces several major challenges in meeting one of its many mandates:

> We are charged, at all levels of government, with serving as advocates for older persons in connection with all issues confronting the lives of older persons.[26]

One of those challenges relates to the relationships of the AoA with other Federal departments and agencies. How can this one unit perform a coordinating function or even an information exchange function?

Another challenge relates to the Administration distaste for so-called "categorical" programs and its insistence that revenue-sharing can do the job better.

Still another of the many challenges facing AoA is the heavy reliance Dr. Flemming would like to place upon funding for services to be made available through what is now called Title XX of the Social Security Act.

A. THE "COOPERATIVE NETWORK" WITH OTHER FEDERAL AGENCIES

Commissioner Flemming is giving major emphasis in 1975 to the development of what he calls "effective interagency working relationships" at the Washington level in hopes that such action will encourage states to do the same.

He provided the following progress report at the April 16 hearing on extending the older Americans Act:

1. *Transportation*—A working agreement with the Department of Transportation is in effect.
2. *Utilization of Volunteers*—A working agreement with ACTION is in effect.
3. *Information and Referral*—A working agreement with the Social Security Administration and the Social and Rehabilitation Service has been developed. A second working agreement with eleven departments and agencies outside of the Department of Health, Education, and Welfare is also in the final stages of negotiation.
4. *Medicaid Services*—A working agreement has been developed and signed by the Administration on Aging and the Medical Services Administration.
5. *Rehabilitation Services*—A working agreement between the Administration on Aging and the Rehabilitation Services Administration has been signed.
6. *Health Services*—A working agreement has been developed between the Administration on Aging and the Public Health Service and is in effect.
7. *Use of Schoolbuses for the Elderly*—An agreement which will involve the Department of Transportation and the Office of Education is being negotiated in final form.

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[26] From testimony before Senate Subcommittee on Aging, Apr. 16, 1975.

8. *Housing*—A joint issuance that identifies those parts of the Housing and Community Development Act which provide opportunities to assist older persons has been signed by the Administration on Aging and the Department of Housing and Urban Development.

9. *Research on Aging*—An Interdepartmental Task Force on Aging has issued a request for proposals for a joint contract to inventory Federal Research on Aging. Nine departments and agencies are involved in this project.

10. *Coordination with School Lunch Programs and Facilities*—The Office of Education and the Administration on Aging have signed an agreement in this area. The Deputy Commissioner of the Office of Education and I have met with the national organizations working in the area of education to explain and discuss this agreement.

11. *Energy*—An agreement designed to assist low-income older persons to winterize their homes has been reached, involving the Departments of Agriculture, Labor, Housing and Urban Development, the Federal Energy Administration, the new Community Services Administration, and ACTION.

12. *Housing and Nutrition*—A joint agreement between the Department of Housing and Urban Development and the Administration on Aging has been signed designed to facilitate the use of public housing facilities as sites for nutrition projects.

Commissioner Flemming, in conversations with Congressional personnel, has acknowledged that such agreements do not guarantee results. But he believes that they can help assure better use of present and potential resources for delivery of services to older Americans.[27]

B. QUESTIONS ABOUT REVENUE-SHARING [28]

Commissioner Flemming has repeatedly urged state and local officials on aging to make full use of revenue-sharing on behalf of the elderly.

He points to the fact that the State and Local Fiscal Assistance Act of 1972 [29], in its title on general revenue sharing, lists as a priority expenditure: "Social Services for the poor or aged."

Area agencies on aging designed to make full use of whatever resources are available to provide services for older Americans—thus are urged to do all in their power to take advantage of that provision in the law.

And, in a growing number of cases, revenue-sharing money is helping older Americans. A few examples: [30]

Montgomery County, Pa.: In fiscal year 1973 alone, Montgomery County, Pennsylvania provided $672,089 to a county geriatrics center to cover operating expenses, $3,700 to the Human Services Council which coordinates the activities of various organizations aiding the aged and poor, and $1,800 to the Senior Adult Activity Center.

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[27] In reply to a letter from Senator Church inquiring about the status of the inter-agency agreements, Commissioner Flemming gave this information about implementation: "I have asked our Regional Office staff to monitor these agreements, and provide technical assistance to the States in the implementation of the agreements. Based on this monitoring and the experience gained working with the agreements, revisions will be made, as appropriate. In two instances, I have polled the States to request a report on their activities in relation to working agreements, and in one case, with ACTION, a new agreement was developed based on the results of these reports. I would expect this process to be reported as the State and Area Agencies on Aging gain further experience implementing respective agreements."—Letter dated Mar. 2, 1975.

[28] For additional discussion of revenue-sharing, see "New Federalism and Aging," a paper written by C. L. Estes, Ph.D. It appears as Appendix 3 of this report, p. 150.

[29] Public Law 92–512, signed Oct. 20, 1972.

[30] Examples provided to the committee in December 1974.

Hamilton, Ohio: Some general revenue sharing money was used to equip and landscape the senior citizens center. Shared revenues will also help to provide reduced-rate bus tokens to the city's elderly. Those who are unable to pay even this reduced rate will be provided free bus service.

Dallas, Tex.: Using revenue sharing dollars, the Human Development Services Fund has provided $5,000 a month for the three months for a "meals on wheels" program which delivers meals to the aged in their homes.

Clay County, Iowa: During fiscal year 1974, Clay County allocated $40,000 or about 25% of its shared revenues for medicine and other support of elderly residents in nursing homes in surrounding counties. Clay County does not have its own nursing home.

Dover, Del.: Dover has provided $3,200 to the Elderly Telephone Reassurance program, $10,710 to the Mature Adult Nutrition Agency, $10,000 to the Hamington Senior Center, $10,000 to the Milford Senior Center, and $15,000 to the Geriatric Services of Delaware.

Seattle, Wash.: More than $2.2 million has been spent in Seattle for elderly care programs and child care centers.

Charlottesville, Va.: Charlottesville allocated about 27% of its revenue sharing funds to social services for the aged and poor. Among the programs funded is one that provides recreation and other activities for senior citizens.

Salem, Oreg.: The city of Salem plans to acquire and develop a community building for senior citizens using $100,000 of its revenue sharing money.

Freeport Township, Ill.: The largest expenditure of shared revenues in fiscal year 1974 was for the nutrition program the township sponsors for the aged and poor. The program provides meals five days a week at three different sites. One site, which feeds about 80 people, is located in a government-owned home for senior citizens with limited incomes. Another, located in a church downtown, began with six people and is presently feeding 60. The township also plans to provide a walk-in center in the uptown area, where the elderly can congregate, play cards, and listen to guest speakers.

Dubuque, Iowa: $10,188 went to a private agency called "Concern" which provides educational courses for the elderly, transportation to and from doctors or clinics, and "meals on wheels."

Lee County, Iowa: The "homemaker health services program," received $10,000 to be used for care of the poor and the elderly in *their* homes. $60,000 was granted to defray the cost of extending the second floor of the county home. Thirty-six to forty-eight more people will now to able to receive treatment. The Chairman of the Board of Supervisors says that general revenue sharing has allowed Lee County to meet its number one need: the care of the elderly.

While heartening such examples do not answer fundamental questions.

One of the most important qeustions is: how much general revenue-sharing funds are actually being used for aging-related purposes?

The first report [31] on use of these revenues disclosed in March 1974 that $2.8 billion in Federal funds had been disbursed by June 30, 1973.

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[31] *General Revenue-Sharing—The First Actual Use Reports,* issued by the Office of Revenue Sharing, Department of the Treasury.

Approximately 60 percent had been used for education, public safety, and transportation.

But less than 3 percent had been used for social services for the poor or aged.

A more detailed analysis of actual spending solely on aging by 219 local governments was later provided by the General Accounting Office at the request of Representative Claude Pepper of Florida. A GAO letter of Feb. 13, 1974 to Representative Pepper provided this summary:

> Of the 291 governments, 28 authorized the expenditure of part of their revenue-sharing funds in programs or activities specifically and exclusively for the benefit of the elderly.
>
> "*These authorizations totaled about $2.9 million, or about 2/10ths of 1 per cent of the total funds authorized by the 219 governments.*" (Emphasis added.)

Faced by such statistics—and similar GAO findings of sparse amounts channelled to services for youth and for the handicapped—Representative John Brademas said on the Floor of the House:

> To be as gentle about the point as possible, this record is not impressive and simply supports the apprehensions that many of us in Congress expressed about revenue-sharing when it was first launched with extravagant and pretentious claims.[32]

A similar criticism was made by the National Council of Senior Citizens in a publication[33] issued in April 1975. The NCSC, in a broad summation of governmental concern for the elderly traced the history of revenue sharing and paid special attention to the Nixon Administration criticisms of so-called categorical, or special purpose, Federal programs. Instead, the Administration has advanced revenue-sharing, and block grant, proposals.

Under the heading of "Why Revenue-Sharing is Not the Answer for the Elderly," the NCSC report said:

> The National Council of Senior Citizens is convinced that while revenue-sharing—both general and special—may serve some useful purposes, it does very little to benefit the poor elderly. The threatened absorption, by revenue sharing, of the categorical programs which have been operating especially for the elderly will result in complete elimination or substantial reductions of important and necessary services.
>
> The issue is not one of *either* revenue-sharing or categorical programs. Revenue sharing with specifically earmarked funds for programs for the elderly might be an acceptable alternative in some cases. In the absence of categorical programs or earmarked funds for programs for the elderly, for example, what chance will senior citizens have to promote a program for the elderly to be financed out of local revenue sharing funds against a ballpark?

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[32] H. 5047, *Congressional Record*, June 11, 1974.

[33] *National Policy for Older Americans . . . Response to their Special Needs.*

Such questions will have growing pertinence in 1975 as the Congress prepares to consider extension of the general revenue-sharing program by the end of next year. Already, an Administration Task Force has proposed that Congress extend the program through 1982 with gradual increases until $7.4 billion is reached in that year.[34] All in all $39.85 billion would be spent between 1977 and 1982.[35]

On the one hand, the Congress could decide to seek greater safeguards actually assuring earmarking of funds for the elderly under revenue-sharing. It could also insist upon more aggressive action at the local level in channelling funds for such purposes.[36]

On the other hand, the Congress could take a more skeptical view of revenue sharing and even reduce funding commitments, rather than increase them.

Whatever course is followed, revenue sharing will be on the scene at least until the end of 1976 and probably beyond. AAA directors and others attempting to make use of that program will face difficult decisions in determining just how much dependence should be placed in a program which thus far has made such an unimpressive record in responding to the needs of aged Americans.

C. Title XX and the Older Americans Act

Early in 1975, the new social services amendments were signed into law.[37] A major provision of these amendments allowed for the removal of Titles IV-A and VI of the Social Security Act and establishes a new Title XX—Grants to States for Services. The new Title XX retains the $2.5 billion limitation on annual Federal funding; retains the existing 75 percent matching for most services; repeals the formula requiring that 90 percent of the Federal funding for social services be used for actual welfare recipients and replaces it with a formula which calls for 37.5 percent of the States funds to be used for Aid for Families with Dependent Children, Supplemental Security Income and Medicaid recipients or eligibles; requires fees for services for families or individuals who have incomes exceeding 80 percent of the States median income; and requires that the States provide at least three types of services (to be specified by each State) for the aged, blind, and disabled.

In an effort to assure that the States equitably support services for the aging with Title XX funds, Senator Church included in S. 1426 (Older American Act Amendments of 1975) a provision which directs a State to include in its Title XX plan a description of how the services provided under Title XX will be coordinated with the plans of such programs as Titles III, V, VII, VIII. and IX of the Older Americans Act. Such coordination would, it is hoped, enhance the visibility of aging programs and sensitize other service agencies to the needs and special problems of the aging population.

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[34] *Washington Post*, p. 1. Jan. 4, 1975.

[35] Page 86, *National Journal Reports*, Jan. 18, 1975.

[36] The National Council on the Aging, in its May 1974 publication, *Revenue-Sharing and the Elderly: How to Play and Win*, urged such tactics: "If the public and private, local, state and national agencies do not make a concerted effort to get 'our fair share' of the allocated dollars, no share at all will come to our constituents. That is the nature and indeed, the crux of revenue sharing."

[37] Public Law 93-647, signed into law on Jan. 4, 1975, and to become effective on Oct. 1, 1975.

FINDINGS AND RECOMMENDATIONS

The Older Americans Act, now nearly 10 years old, is making a major contribution to the well-being of a growing number of elderly persons in this Nation. Extension of that act, due to take place in the near future, should provide additional evidence of congressional determination to improve the Older Americans Act, in the face of administration failure to request adequate funds or to propose an adequate bill for extension.

The Congress should also act in 1975 to increase Title III funding at levels sufficient for State agencies on aging and area agencies on aging to do the job required of them by law.

Appropriate congressional units should require regular reports by the administration on aging on inter-agency agreements for cooperative action.

Special attention should be paid in 1975 to possible amendments to the Revenue-Sharing Act for the purpose of making it more responsive to needs of older Americans.

Title XX Social Security Services Regulations should be implemented with maximum flexibility and helpfulness to the elderly.

In view of the rising costs of food, materials, fuel and program operation afflicting the Title VII nutrition programs over the past year, the Committee recommends:

—The full authorization levels for the program (P.L. 93-351) be appropriated and expended ($150 million for fiscal 1975, $200 million for fiscal 1976, and $250 million for fiscal 1977) so that the projects can serve the number of elderly participants who are in need of this program.

—Separate administrative costs under Title VII should be provided under the law to allow the program to operate more effectively and maintain a staff that is necessary for an efficient operation of the program.

CHAPTER VIII

TRAINING, RESEARCH, AND EDUCATION

As the number of elderly rose to almost 22 million over the past year,[1] so grew the attention focused upon research and training in gerontology, the study of aging. But not all of the developments were positive.

As the Administration continued its opposition to categorical training programs, Title IV-A of the Older Americans Act was once again jeopardized. Programs offering long-term and short-term gerontological training in many parts of the nation faced uncertainty as they witnessed a gradual increase in the number of area agencies on aging and nutrition projects and, consequently, a greater demand for personnel sensitive to the needs of the elderly. However, even in the face of increased demand, the Administration once again failed to request any funding for Title IV-A in its budget request for fiscal years 1975 and 1976. Nevertheless, congressional pressure for funding continues.

Another congressional initiative resulted in a major step forward during the past year in regard to Federal concern about gerontology. On May 31, 1974, the Research on Aging Act (P.L. 93-296) was signed into law and created for the first time a National Institute on Aging within the National Institutes of Health (NIH). Almost identical to legislation vetoed in the previous Congress [2], the new law provides for the establishment of the new Institute to serve as a focal point for biomedical, behavioral and social research relating to the aging process.

Another positive trend during 1974 was growing interest in educational opportunity for older Americans.

I. TRAINING—ONCE AGAIN, UNCERTAINTY

Long-term, or university based training, consists of programs within the curriculum of colleges and universities which are degree or career oriented. Previous long-term training grants under the Older Americans Act (Title IV, Part A) have been used to support faculty, students and program costs for gerontological programs and institutes in colleges and universities across the country.

Short-term, or inservice, training is focused on the instruction of individuals in planning, administration, operation and delivery of services to the elderly. Short-term training, as provided under the Act, has been directed to technical assistance, management skills, service implementation, planning and evaluation process on a one-to-one basis, in workshop structures, seminars, symposia, and informal classroom situations. In testimony before the Committee on Aging, Robert Curry, Training Director of the Community Nutrition Institute, defined short-term training as "learning interventions into the working lives of individuals, which are immediately and directly helpful."[3]

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[1] The Census Bureau, in its *Current Population Report* of March 1975 (Series P-20, No. 279), reported that the 65+ population of the United States was 21,815,000 as of July 1, 1974.

[2] S. 887 was pocket vetoed by the President on Oct. 30, 1972.

Other witnesses recognized the need for both long- and short-term training and appreciate the need for a systematic coordination between the two processes. Walter Beattie, Director of the All-University Gerontology Center of Syracuse University, stated:

> Certainly there is a great need for the personnel now directly working with the older persons, who never had any preparation, to have short-term training . . . but we must also pay much attention to the trainers of the trainers, because again as I say in my testimony, so often we have persons of almost the blind leading the blind.[4]

Despite the obvious need, training programs have faced uncertainty and decreases in funding. With the advent of the Older Americans Comprehensive Services Amendments of 1973 (P.L. 93–29), it appeared that training would receive increased support but as indicated by the following table, long-term training has dropped markedly since 1972.

APPROPRIATION AND BENEFICIARY SUMMARY TRAINING GRANT PROGRAM, ADMINISTRATION ON AGING

[Since inception of program]

Fiscal year	Appropriation	Students enrolled: Long-term degree, new and continuing (i.e., total enrollees)	Students enrolled: Short-term nondegree
1966	500,000	12	922
1967	1,493,000	78	946
1968	2,245,000	214	1,475
1969	2,845,000	363	1,751
1970	2,610,000	370	850
1971	3,000,000	452	341
1972	8,000,000	1,000	6,000
1973 (estimate d)	[1] 8,000,000	670	9,000
1974	9,500,000 [3]	625	9,000+
1975	[2] 8,000,000 [3]		

[1] Full amount not to be made availab le for obligation as part of phase out policy.
[2] Full amount included in administrative proposal to be rescinded for fiscal year 1975 (Rescission 75–79 OHD–AoA).
[3] To be divided betwaan support of long - and short-term training.

However, in its 1973 budget request for the following fiscal year the Administration attempted to reduce and even withdraw support. A history of the struggle follows:

1973.—The Administration failed to request any funding for training in the field of aging in its budget request for fiscal year 1974. The Congress responded by appropriating $9.5 million for training for fiscal year 1974. Administration responded to Congressional appropriation for fiscal year 1974 by directing 10% of the $9.5 million for administrative purposes and dividing the remainder between short and long-term training programs.

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[3] Testimony before the Senate Special Committee on Aging, "Training Needs in Gerontology," Mar. 7, 1975.

[4] Testimony at hearing cited in footnote 2.

1974.—Administration failed to request any funding for training in budget request for fiscal year 1975.

Congress responded by appropriating $8 million for training for fiscal year 1975.

Administration responded by proposing a rescission of the total $8 million appropriated for fiscal year 1975.

1975.—Congress responds to proposal by disapproving the Administration's rescission measure, thus releasing the funds to be obligated by the Department.

Administration failed to request any funding for training in its budget request for fiscal year 1976.

This chronology was described by Sen. Lawton Chiles as a "trip around the mulberry bush." [5] He indicated that congressional support of the funding will most likely continue on a year-to-year basis if forced to do so. However, this method of funding relies on one-year grants with no secure support for future planning and expansion. A long-range, structured training program would significantly enhance the possibilities and productivity of both short- and long-term training programs.

II. RESEARCH—A NEW INSTITUTE ON AGING

> The goal of the National Institute on Aging will be to provide, through biomedical research and socioeconomic as well as environmental studies, the means to help lessen the burdens that are the accompaniment of longer life. Longer living need not be equated simply with survival. We should strive to improve the quality of life, the style of life. The aging individual can be productive—despite many handicaps or diseases to which man is heir. He or she can be an economic asset rather than a national liability.[6]

Dr. Robert B. Greenblatt, President of the American Geriatrics Society, expressed this impressive objective for the new Institute at oversight hearings on "Establishing A National Institute on Aging." Under terms of the Congressional mandate, the new Institute is responsible for "the conduct and support of biomedical, social, and behavioral research and training related to the aging process and the diseases and other special problems and needs of the aged." [7] The Institute is directed to carry out public information and education programs, disseminate findings to the general public, and prepare a comprehensive aging research plan for presentation to the Congress. The focus of this plan has been a major point of discussion with gerontologist and geriatricians throughout the country. There are those who feel that the thrust should be purely biological and biomedical, dealing specifically with methods of slowing down the aging process; or, as Dr. Alexander Comfort describes it "finding means whereby humans would take 70 years to reach 60."

On the other side of the issue, there are those who believe that focusing an Institute's efforts and resources primarily on research related to the aging process could cause even greater social and economic conditions.

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[5] Remarks while presiding over hearings for "Training Needs in Gerontology," Mar. 7, 1975.

[6] Testimony before the Senate Special Committee on Aging, "Establishing a National Institute on Aging," Aug. 1, 1974.

[7] Public Law 93–296.

Dr. Ewald W. Busse, then President-Elect of the American Geriatrics Society, testified:

> We are not only obligated in searching for biological explanations, we are very obligated to look at the social and physical environment to see what adverse forces impinge on the individual. So that, in my viewpoint, as the new Institute emerges, it will be very shortsighted not to recognize as we move in the basic science of aging, how we can relate organic changes, social stress, and how the individual functions in society. Hostile features in the environment can be altered to reduce the adverse manifestations of many diseases.[a]

The direction which the National Institute on Aging will take will be significantly influenced by the Institute's new Director, the Institute's Advisory Council on Aging—which according to the law is to advise, consult with and make recommendations to the Secretary—and on the influence of those in the field of aging who are knowledgeable and concerned about the Institute's role.

Clearly, its goals and means will also be seriously affected by the Institute's budget. The Administration is requesting $16.9 million for the new Institute in its budget request for fiscal year 1976. This is a slight increase over the previous year's budget of approximately $15.74 million (amount transferred from the Adult Development and Aging Branch of the National Institute of Child Health and Human Development plus an additional amount for pro-rated management costs). *However, when compared with the budgets of other institutes under the umbrella of the National Institutes of Health, the National Institute on Aging's budget is by far the most limited.*

In testimony before the Committee on Aging, the American Gerontological and Geriatric Societies recommended a budget of $49.5 million for fiscal years 1975 and 1976.[b] They reasoned that the staff of approximately 152 of the intramural program at the Baltimore Geriatric Center and the staff of 10 from the NICHD's Adult Development and Aging Branch could be transferred to the new Institute and an additional number of staff could be brought aboard to expand the aging research program. Under the Administration's budget proposal, there could be little if no expansion of the program which had been active under NICHD.

THE CHALLENGE

Dr. Carl Eisdorfer, Chairman of the Department of Psychiatry and Behavioral Sciences, School of Medicine, University of Washington (Seattle) and Chairman of the Research, Development, and Manpower Committee of the Federal Council on Aging, stated in testimony before this Committee:

> I take second place to no one in my concern for enriching life and for maintaining the integration, or reintegration of Americans of all ages and backgrounds into the mainstream

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[a] Testimony at hearing cited in footnote 6.
[b] Testimony at hearing cited in footnote 6.

> of active participation. We have to be very careful, however, of the role this particular Institute should play, and I would hope that its friends would be able to support the directorship group, in their attempts to make it a viable oriented program, but one thing I believe we lack most in this field of aging is a strong base of knowledge which we can then apply.[10]

Dr. Eisdorfer's concern has been expressed by others who seek answers to the mysteries of aging. Dr. Greenblatt, for example, listed as possible avenues of inquiry:

> (1) Why the longevity of certain ethnic groups—far beyond that found in the United States of America? Is it due to genetics, chromosomal, nutritional, or environmental factors?
>
> (2) Is aging synonymous with senescence and decay?
>
> (3) Is aging merely a predominance of catabolism—tissue breakdown—over anabolis—tissue buildup?
>
> (4) Is aging a cellular phenomenon—an inability to renew itself because of autoimmune factors?
>
> (5) Is aging endocrinologic loss of tissue responsiveness to normal or declining hormonal function?
>
> (6) How is aging affected by socioeconomic and environmental forces? [11]

A soundly funded and supported Institute on Aging could give sustaining stimulus to broaden substantially the knowledge base of the fields of gerontology and geriatrics and influence the degree of research being conducted in related institutes and laboratories. The birth of this new Institute on Aging opens the doors for better coordination and understanding among the research segments on the aging process, extending longevity, deferring of senility, understanding the correlation of aging and cardiovascular diseases, and the other physical and mental malfunctions which are associated with growing old. The struggle to create such an Institute has been won; now, the more difficult task of supporting and shaping the Institute's future lies at hand.

III. EDUCATION FOR THE OLDER STUDENT

Institutions of higher education in recent years have faced circumstances which tend to encourage higher enrollment of older students: decreases in their enrollment of younger students, the expressed needs and desires of their communities, the initiative of their own faculty or students, and/or the State legislation which opens their doors to nontraditional student.

The "graying of the classroom" has awakened the world of academia to many possibilities and responsibilities of serving their entire communities as life-time learning centers. Administrators and professors are seeking guidance on more sensitive and informed methods of teaching and relating to the older student.

Programs specifically designed for the older student exist in every State of the nation. Some programs have been self-initiated by educators; some have resulted from pressure from the elderly for such programs; and quite recently many have resulted from State statutes which offer reduced or free tuition. Some examples:[12]

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[10] Testimony at hearing cited in footnote 6.
[11] Testimony at hearing cited in footnote 6.

> Hawaii passed a bill allowing persons 60 and over to attend State institutions of higher education on a tuition-free, space available basis.
>
> The Maryland legislature enacted legislation which allows persons 60 and over to waive tuition charges for enrollment in the State's community colleges. A bill extending the same privilege to State institutions of higher education for persons 60 and over was before the State Assembly at this writing.
>
> Virginia's legislature passed a bill which allows for persons 65 years of age and over to attend classes in all the State institutions on a space available basis. Elderly are eligible to either audit courses for credit or take them for non-credit. If a person takes the course for credit, he or she must pay unless income is below $5,000.
>
> The University of Maine offers a waiver of tuition for persons 65 and older who register for undergraduate courses on either a credit or non-credit basis.
>
> The University of Nevada system offers those 62 and older a reduction in tuition to $10 to audit classes. The community colleges offer a reduction in tuition to $3 per credit hour for those 62 and over.
>
> The University of Wisconsin system enables those 62 and over to audit courses at any campus on a tuition-free basis. If the older student wishes to take the course for credit, he or she must pay the normal charge per credit.

The above examples show those institutions which provide strictly educational benefits to the older student. Other programs are offering supportive services, as well. Several programs conduct seminars, workshops and classes at senior centers after the elderly have chosen the subjects they wish to explore. Other institutions and community colleges have extended their resources to provide special counseling and advising to the older student, special transportation programs, nutrition and health services and on-campus jobs which range from tutoring and babysitting to gardening and financial advising. Kirkwood Community College (Iowa) and the College of Southern Idaho act as area agencies on aging under the Older Americans Act. (See Chapter VII, for discussion of AAA's.) Kankakee Community College (Illinois) offers courses in pre-retirement in outlying communities and in-plant situations for employees. Local businessmen aid in covering the cost of the program. Clemson College (South Carolina) administers week-long camping sessions for low-income persons 65 years and over.

Whatever their objective or the content of their program, the institutions which create special programs for the elderly within their framework must consider such items as accessibility to their campus and to the individual buildings, transportation to and from the campus, acceptable scheduling times, method of instruction and communication, course content, composition of class participants (all elderly or mixed generational), residential possibility on the campus, adequate health facilities and available meal services. These are but a few of the specifics which the program organizers must become sensitive to and adapt their programs around. The community of elderly can be tapped and given the opportunity to describe needs and preferences.

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[12] Example provided in correspondence from state agencies on aging to Senate Committee on Aging, 1975.

Support for education programs for the older student has historically come from various sources, e.g. Federal funds, State assistance, local funds, and university contributions. In a survey of the country's education programs for the elderly the Academy for Educational Development (AED) estimated that the largest support comes from tuition costs and fees.[13] The AED found numerous support sources in the programs they surveyed as shown in the following chart:

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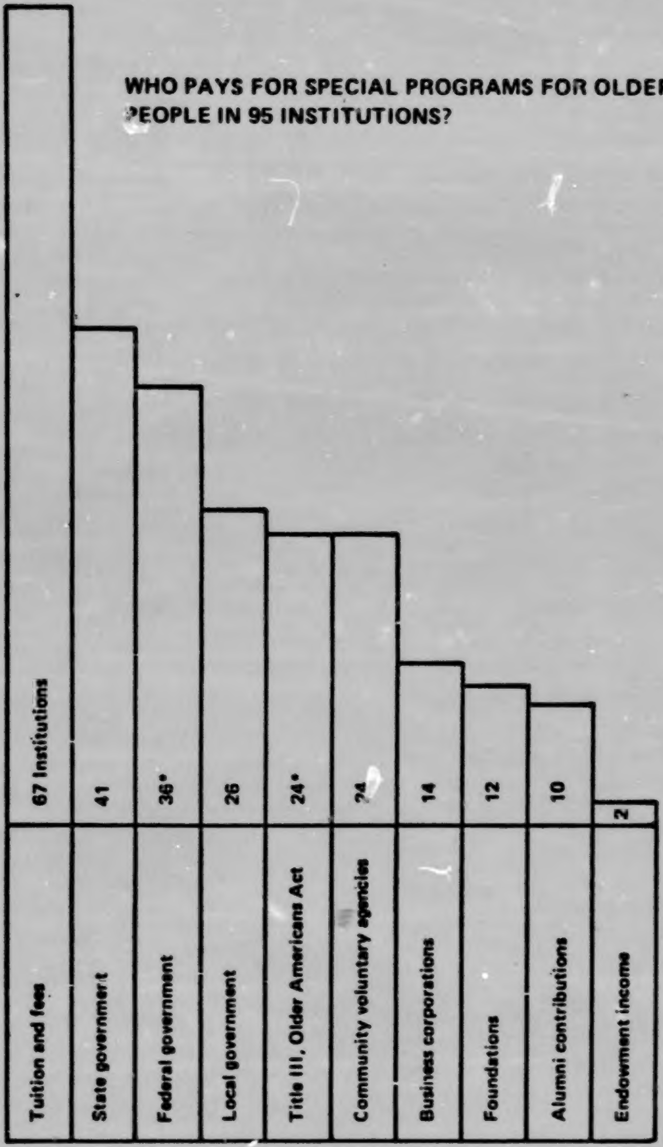
[13] Never Too Old to Learn, a report submitted to the Edna McConnell Clark Foundation by the Academy for Educational Development, Inc., New York, June 1974.



WHO PAYS FOR SPECIAL PROGRAMS FOR OLDER PEOPLE IN 95 INSTITUTIONS?

*Some overlap exists between these two categories.
Source: AED Survey 1974

The educational backgrounds of the some 22 million elderly of our nation vary from individual to individual. With that background comes years of experience and knowledge which are a source of education in themselves. An elderly's presence in the classroom can be as beneficial to the others present as to themselves. With the aging population continually increasing, their presence is beginning to significantly influence the educational process in a manner which can be the beginning of another community-oriented role of education.

FINDINGS AND RECOMMENDATIONS

During the past decade, the availability of services for the elderly has increased in great leaps, creating an obvious gap between the services available and the amount of personnel and knowledge regarding these programs. In view of this situation the Committee recommends:

> **The Administration should request and support budget levels for Title IV–A training that reflect the demand for such trained personnel in the field of aging.**
>
> **Title IV, Part C, providing for multidisciplinary centers of gerontology should be funded at adequate levels to allow such centers to serve their regions in training and research preparations concerning gerontology.**
>
> **The newly created National Institute on Aging should receive an increased funding level within the National Institutes of Health which would place it in a more equitable position of competition and production with the other Institutes.**

Educational opportunity for older Americans is growing at a rapid rate. The time has come for coherent attention and action by appropriate Federal and State agencies in conjunction with leaders in education. The Senate Committee on Aging will give extensive attention to this area during the next year and will provide a summary of major trends.

CHAPTER IX

TRANSPORTATION: STILL UPHILL

> "The character of the transportation problem faced by older Americans as expressed in the transportation background paper of the 1971 White House Conference on Aging remains unchanged; the elderly are not well served by the transportation facilities available to them."
>
> —Joseph S. Revis,[1] December 1974.

Assessments of mobility problems faced by older Americans usually point to several major root causes:

—Retirement income is often inadequate for purchase of the transportation services needed.

—Public transportation—when it is available—is generally directed to work related trips and not to the unique needs of the older person.

—The automobile, the dominant transportation mode, often is ruled out because of income or physical limitations.

—Architectural and psychological barriers reduce attractiveness of those public transit systems that are available to older persons.[2]

The practical consequences of such problems were described in an April 1975 National Council of Senior Citizens publication, "A National Policy for Older Americans . . . Response to their Special Needs":

> Lack of transportation is like having a modern kitchen with all the latest appliances and no electricity. Lack of transportation is a barrier to obtaining necessities and necessary services; a barrier to socializing; a barrier to participating in activities, a barrier to mental growth or even keeping one's sanity. Lack of transportation is a cause of stress and worry, loneliness, hunger, undue suffering and, in fact, might be a cause of death.

The urgency of the problem has caused mounting demands for coherent and effective governmental action.

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[1] Mr. Revis, Senior Consulting Associate of the Institute of Public Administration, was the author of the 1971 White House conference background paper cited in the above quotation, which appeared in *Transportation for the Elderly: Action at the Local Level*, prepared for the National Forum on Aging for Local Government Official, sponsored by the National Retired Teachers Association-American Association of Retired Persons, Washington, D.C.

[2] See *Older Americans and Transportation: A Crisis in Mobility:* Senate Report No. 91–1520, Senate Special Committee on Aging, December 1970; and Chapter X. "Transportation and Other Consumer Issues, in *Developments in Aging: 1973 and January–March 1974*, Annual Report, Senate Committee on Aging, May 13, 1974, for additional details. A more recent appraisal appears in *Transportation for the Elderly: The State of the Art*, Department of Health, Education, and Welfare Publication No. (OHD) 75–20081. This publication is intended to provide a general overview of special projects designed to help the elderly and to examine specific "case-study" projects. The study was undertaken in response to requirements under Title IV, Section 412 (a) of the 1973 Older American Act Amendments, which ordered a study of this nature.

In 1974 and in early 1975, there were signs of progress toward that end:

- —Legislative enactments further spelled out a Federal responsibility for improving mobility opportunity for the elderly.
- —Court action resulted in accelerated inter-departmental action intended to speed action and clarify responsibilities and goals.
- —The Administration on Aging was preparing in April 1975 to issue recommendations emanating from a special study and its own round of hearings, even as the Department of Transportation considered regulations to make transportation more accessible to the elderly and the handicapped.

Progress, however, was uphill. Important questions were raised about the multiplicity of Federal programs which provide limited help through specialized transportation projects. Delays and apparent confusion also deepened in regard to a grant and loan program intended to assist in providing transportation needs to meet the special needs of the elderly and the handicapped.

I. THE ENACTMENTS: BUILDING UPON THE 1970 MANDATE

The first Congressional statement on recognizing the mobility problems of the transportation deprived was a 1970 amendment to the Urban Mass Transportation Act which stated:

> It is hereby declared to be the national policy that the elderly and handicapped persons have the same right as other persons to utilize mass transportation facilities and services; that special efforts shall be made in the planning and design of mass transportation facilities and services so that the availability to elderly and handicapped persons of mass transportation which they can effectively utilize will be assured; and that all Federal programs offering assistance in the field of mass transportation (including the programs under this Act), should contain provisions implementing this policy.

In addition, the amendment gave discretionary authority to use $46.5 million to adapt transit systems for better service to the elderly and handicapped.

At hearings early in 1974,[3] witnesses complained that progress under the 1970 amendment had been slow, and that the Urban Mass Transportation Administration had no strong commitment to this type of capital expenditure.

In 1974, important new developments occurred:

National Mass Transportation Act: This landmark legislation[4]—which had Senator Harrison Williams and Representative Joseph Minish as chief sponsors—requires in Section 5 (m) that rates charged the elderly and handicapped persons during non-peak hours in DOT-funded projects are not to exceed one-half the rate applied to general transit users during peak hours.

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[3] "Transportation and the Elderly: Problems and Progress," U.S. Senate Special Committee on Aging, Feb. 24, 27, 28, 1974, Washington, D.C., Senator Lawton Chiles, presiding.

[4] Public Law 93-503, Nov. 26, 1974. In addition to the provisions mentioned above, the Act provided 3.9 billion in funding for operating subsidies and 7.8 billion for capital grants over a 6-year period.

As DOT has commented:[5]

> Implementation of this provision should aid in alleviating the economic constraints which impeded the use of transit by many elderly citizens. In addition, it should effectively supplement UMTA's other activities devoted to reducing physical barriers to the use of transit by these individuals.

The 1974[6] Federal-Aid Highway Amendments: This legislation, in another attempt to clarify Congressional intent on accessibility to transit facilities and equipment, said:

> The Secretary of Transportation shall require that projects receiving Federal financial assistance . . . shall be planned, designed, constructed and operated to allow effective utilization by elderly or handicapped persons who, by reason of illness, injury, age congenital malfunction, or other permanent or temporary incapacity or disability, including those who are non-ambulatory wheelchair bound and those with semi-ambulatory capabilities are unable without special facilities or special planning or design to utilize such facilities and services effectively. The Secretary shall not approve any program or project to which this section applies which does not comply with the provisions of this subsection requiring access to public mass transportation facilities, equipment and services for elderly or handicapped persons.[7]

Rider to Appropriations Act: Finally, Congress took one other step in 1974 to strengthen its intent to develop a transit system that in the future will be accessible to the elderly and handicapped. An amendment by Congressman Biaggi to the Department of Transportation Appropriations Act prohibited the use of funds for services that were not accessible to the elderly and handicapped. The amendment stated:

> None of the funds provided under this Act shall be available for the purchase of passenger rail or subway cars, for the purchase of motor buses or for the construction of related facilities unless such cars, buses and facilities are designed to meet the mass transportation needs of the elderly and the handicapped.[8]

Significance of the Baltimore Suit: Implementation of Federal laws is sometimes speeded along by court action or the prospect of such action.

This occurred in 1974, when two organizations, "Disabled In Action of Baltimore," and the "Maryland Advocates for the Aging" filed suit against the Maryland and U.S. transportation officials and won a written pledge intended to meet their objections.

At issue was a plan by the Baltimore Mass Transit Authority to use a UMTA capital grant to purchase 205 new buses.

The plaintiffs complained that the new buses could not accommodate the needs of the elderly and handicapped.

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[5] See DOT statement in Appendix 1 of this report.

[6] In 1973, the Federal Aid Highway Act had increased the amount the DOT Secretary can channel on behalf of the elderly and the handicapped from 1½ to 2 percent.

[7] Public Law 93-643, approved Jan. 3, 1975.

[8] Public Law 93-391, approved Aug. 28, 1974.

Their suit complained:

> Denial of access to public transit vehicles deprives them of their constitutional guarantee of equal protection of the laws and their rights under the Urban Mass Transportation Act and other Federal laws.[9]

Faced with the possibility of prolonged litigation, the U.S. Department of Transportation worked with other defendants—including the Mass Transit Administration of the Maryland Department of Transportation—to develop a Memorandum of Understanding which meet the objections of the plaintiffs.

That Memorandum said, among other things:

> The United States Department of Transportation will propose rules and regulations within one year governing the planning and design of mass transportation facilities and services to assure the availability to elderly and handicapped mass transportation which they can effectively use.[10]

In addition, it required the U.S. DoT and the Maryland Mass Transit Administration to guarantee in the Baltimore transportation system: (1) reserved seats for elderly and handicapped passengers, and (2) the purchase of 10 buses equipped to meet the needs of wheelchair-bound persons.

The proposed rules required by the agreement were published on February 26, 1975,[11] and they are applicable to all transportation services which receive DoT funds, not merely the Baltimore system. Transportation planning requirements of the new rules require that the all unified work programs for planning assistance must include a provision to meet the transportation needs of the elderly and the handicapped. In addition, DoT now requires information on population distribution of elderly and handicapped persons be included in the plan. It also requires adequate consideration to present transportation services and a detailed description of whatever alternative services may exist.

II. LINGERING PROBLEMS

Actions taken by the Congress and through the Baltimore Memorandum of Agreement bode well for future development of a more coherent Federal policy to carry out the 1970 declaration that "all elderly and handicapped persons have the same right as other persons to utilize mass transportation facilities and services."

Another positive development was the publication early in 1975 of an Administration on Aging study[12] which provides the most comprehensive analysis yet of Federally-assisted programs or projects designed to help transportation-deprived Americans.

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[9] Complaint for Injunctive, Declaratory and Mandamus-Like Relief in the United States District Court, District of Maryland, Civil Action No. NM 74–1069, Oct. 2, 1974.

[10] Memorandum of Understanding, 30th Day of October 1974. Plaintiffs, Disabled in Action of Baltimore and Maryland Advocates for the Aging. Defendants, Maryland Department of Transportation, United States Department of Transportation, and General Services Administration, in the United States District Court for the District of Maryland.

[11] *Federal Register*, Wednesday, Feb. 26, 1975, Washington, D.C. Volume 40, Number 39, Part III. Department of Transportation Urban Mass Transportation Administration. "Elderly and Handicapped Transportation Services" Codification of Requirements.

[12] *Transportation for the Elderly: The State of the Art*, described in footnote 2.

This publication—and the Administration on Aging's prompt decision to conduct hearings [13] on issues it raised [14]—provide helpful impetus to more coherent Federal action in this area.

But two problems persist, one arising from Section 16(b)(2) of the mass transportation legislation, and more general problems arising from the multiplicity of Federal programs which provide many, but small, amounts of transportation assistance.

A. DELAYS ON 16(b)(2)

Amendments to the Federal Aid Highway Act of 1973—in Section 16(b)(2) instructed the Secretary of Transportation to make grants and loans to private nonprofit corporations and associations to assist in providing transportation to meet special needs of the elderly and the handicapped.

To assure maximum coordination, the U.S. Department of Transportation and the Administration on Aging entered into a working agreement on June 21, 1974. One of the objectives was to encourage similar agreement by state units on aging and on transportation.

A later working agreement—dated July 19, 1974—was also issued; and it declared that the Department of Transportation had set aside $20 million for capital assistance grants and loans to implement 16(b)(2).

However, at this writing, no State has received funds under 16(b)(2). Instead, Commissioner Flemming has complained that many state or area agencies on aging are using Title III funds under the Older Americans Act for transportation purposes when in fact Section 16(b)(2) funds would be more appropriate.[15]

An AoA status report on 16(b)(2) received by the Senate Committee on Aging in February 1975, provides numerous examples of concern or confusion about the lag in providing 16(b)(2) funds.

B. THE FEDERAL "MAZE" ON TRANSPORTATION

The 1975 AoA "State of the Art" study [16] described, in some detail, the many Federal programs which in one way or another offer the promise of assistance in funding transportation projects for older Americans. (See Chart 1 for details).

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[13] AoA hearings were conducted in Philadelphia, Pa., Feb. 14, 1975; Kansas City, Mo., Feb. 20, 1975; Sanford, N.C., Mar. 1, 1975; and San Francisco, Calif., Mar. 3, 1975.

[14] AoA Commissioner Flemming plans to offer recommendations to the Congress by mid-1975 based upon the hearings, the report, and other studies available to AoA.

[15] This testimony was given on Feb. 4, 1974, on p. 302 of hearings cited in footnote 3, before the working agreements were signed. But the problems to which the Commissioner referred remain largely unchanged.

[16] See footnote 2 for details on this study.

CHART 1.—MAJOR FEDERAL FUNDING SOURCES PROVIDING TRANSPORTATION FOR OLDER AMERICANS AS OF OCTOBER 1974

Department, statute, title and section	Description	Appropriated, funding level fiscal year 1974 (millions)	Provides transport for	Elderly share	User eligibility restrictions: Age	User eligibility restrictions: Income work status[2]	User eligibility restrictions: Health/education/other	Area coverage	Capital purchase
A. Department of Health, Education, and Welfare:									
1. Older Americans Act of 1965 as amended:									
Title III, all sections except 308.	State and community programs on aging.	96.0	Broad social services.	Exclusive	None	Priority:DOC		Planning and service areas.	Prohibited.
Title III, sec. 308	Model projects	5.7	Model projects	do	do	None		Varies[3]	Do.
Title IV, sec. 412	Transportation study and demonstration projects.	None	Demonstrations and studies.	do	do	do		Rural emphasis[5]	Possible[6].
Title VII	Elderly nutrition	99.6	Nutrition sites	do	60+[1]	One criterion DOC[4]		Urban,[7] rural	Do.
Title IX	Elderly community services.	10.0	Project activities	do	55+	OMB/unemployed.		Community	Do.
2. Public Health Service Act of 1944 as amended:									
Title III, sec. 314(d)	Comprehensive health services.	90.0	Broad health services.	Moderate	None	None		do	Allowable with approval.
Title III, sec. 314(e)	Community health centers.	209.1	Health sites	do	do	do		Community[8]	
Title XII	Emergency medical services.	27.0	Emergencies	do	do	do	Critical condition.	Established service area.	
3. Social Security Act of 1935 as amended:									
Title VI Title VI	Services for aged blind and disabled.	[13] 365.0	Approved services.[9]	Predominantly	At least 60+	SSI recipient or applicant[11]		State	Prohibited.
Title XIX	Medicaid	5,255.0	Medical	Aged, blind, disabled, AFDC.		SSI eligibility criteria or more restrictive criteria at State option.[12]		do	Do.
4. Mental Retardation Facilities & Community Mental Health Centers Construction Act of 1963 as amended—title II.	Mental health centers.		Mental health services.	Moderate	None	None	None	Areas of 75,000 to 200,000.	Allowable.
5. Vocational Rehabilitation Act of 1973.	Vocational rehabilitation.	700.0	Any vocational rehabilitation services (including medical).	Small[10]	do	Unemployed	Handicapped but employable.	State	Do.

CHART 1.—MAJOR FEDERAL FUNDING SOURCES PROVIDING TRANSPORTATION FOR OLDER AMERICANS AS OF OCTOBER 1974—Continued

Department, statute, title and section	Description	Appropriated, funding level fiscal year 1974 (millions)	Provides transport for	Elderly share	User eligibility restrictions: Age	User eligibility restrictions: Income work status[2]	User eligibility restrictions: Health/education/other	Area coverage	Capital purchase
6. Higher Education Act of 1965 as amended, title I, secs. 101-102.	Community service	14.3	Continuing education.	Moderate	Adult	None	Some college education.	Within reach of college.[11]	Prohibited.
7. Library Services and Construction Act of 1965 as amended—title I.	Library services	44.2	Library services	do	None	do	Priority: handicapped disadvantaged.	Priority: poverty areas[12]	Possible.
8. Appalachian Regional Development Act of 1965 as amended:									Allowable.
Title II, sec. 202	Health demonstrations.	41.8	Comprehensive health services.	Large	do	do	None	Counties of 13 States in Appalachia.	
Title III, sec. 302(a)	Research, demonstrations.	5.5	Demonstration only.		do	do	do		
B. Department of Transportation:[26]								Urban[26]	Do.
1. Urban Mass Transportation Act of 1964 as amended:									
Sec. 3	Capital grants	876.0						do	Do.
Sec. 6	Research and demonstrations.	79.0						do	Do.
Sec. 9	Technical studies	37.0						do	Do.
Sec. 16(b)(2)	Grants to private nonprofit bodies.	[27]20.0	Elderly and handicapped.					Rural	Allowable except rail.
2. Federal-Aid Highway Act of 1973—sec. 147.	Rural highway demonstrations.	[27]9.7						Rural up to 10,000.	Allowable.
C. Department of agriculture: 1. Consolidated Farm and Rural Development Act of 1972: Title III, sec. 360(a).	Loans for essential community facilities.	[13]50.0		Moderate					
D. Department of Labor: 1. Comprehensive Employment and Training Act of 1973: Title III.	National older workers program.	24.0	Work duties	Exclusive	55+	OEO/"chronically unemployed".	None	Varies: primarily city- or county-wide.	Prohibited.
E. Office of Economic Opportunity: 1. Economic Opportunity Act of 1964 as amended:									
Title II, Secs. 212 and 221	Communityaction programs (CAP).	[14]358.8	Broad social services.	Moderate	None	OEO, but broad	do	Urban or rural	Allowable with approval.[15]
Title II, Sec. 222(a)(5)	Emergency food and medical services.	22.4	Broad nutrition and medical services.	Substantial[16]	do	None	Suffering from hunger.	Most are run by CAP's.	Allowable.[17]
Title II, Sec. 222(a)(7)	Senior opportunities and services.	10.2	Broad social services.	Exclusive	[18]61+	OEO, but flexible.	None	Urban or rural	Possible use 221 moneys.
Title II, Sec. 232(a)(e)	Research and pilot programs.	[19]35.6	Special needs	Moderate	61+	OEO	do	Rural focus	Allowable with approval.

F. Veterans' Administration: 1. Veteran Health Care and Expansion Act of 1973: Title I, sec. 101(b).	Expanded medical care.	[20] $2,800.0	VA medical facilities.	Substantial number [21]	None	None	Veteran	Nearest appropriate medical facility.	Leased vehicles allowed.
G. Action: 1. Domestic Volunteer Service Act of 1973:									
Title II, sec. 201	Retired senior volunteer program.	15.0	Volunteer stations.	Exclusive	60+	None/retired	Able to work	Community	Allowable with prior approval.
Title II, sec. 211(a)	Foster grandparents program.	25.0	Program duties	do	60+	OEO/retired	Able to help children.	One or more communities.	Do.
H. Revenue sharing: 1. State and Local Fiscal Assistance Act of 1972.	Revenue sharing	45,970.0	Funds can be used for any purpose. [22]	Varies by State and locality.				States, local jurisdictions.	Allowable.

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[1] Plus spouse of any age.

[2] The following symbols are used: "DOC"—Department of Commerce poverty guidelines, based on Census Bureau statistics; "OMB"—Office of Management and Budget poverty guidelines; "OEO"—Office of Economic Opportunity poverty guidelines; "SSI" supplemental security income levels.

[3] May be statewide or communitywide. Regulations specify that project area must have "large number" of elderly.

[4] Regulations allow the elderly to qualify on any or all of 4 grounds: (1) cannot afford to eat "adequately" (2) lacks skills to prepare well-balanced meals; (3) has "limited mobility"; (4) feels lonely and rejected.

[5] At least 50 percent of projects must be in States predominantly rural.

[6] AOA policy is to encourage capital purchase for demonstrations through joint DOT participation.

[7] Both must have high proportion of elderly poor.

[8] Since these projects originated in the Office of Economic Opportunity most are located in areas of low-income population.

[9] State services vary, and transportation is optional.

[10] An estimated 2.5 percent of those rehabilitated are age 65+.

[11] Emphasis on urban and surburban areas.

[12] Has not completed high school; has limited English skills, lives in area with a culture different from his own.

[13] Water and waste funded separately.

[14] This was a 7-month appropriation.

[15] Survey of existing resources must first be taken. Equipment costing $500 or more must have regional approval.

[16] Focus is on elderly and children, although program also includes families and individuals generally.

[17] But only if vehicles extend the coverage of existing service programs, Emphasis is on better use of existing vehicles.

[18] For general services. For employment and volunteer services, the age requirement drops to 55+.

[19] This figure represents 20 percent of OEO "local initiative money" appropriated for a 7-month period and available for community action programs. Thus, it represents not additional money, but part of the funds listed above for title II, secs. 212 and 221.

[20] Of this amount, $29,200,000 was budgeted for travel.

[21] As of June 30, 1974 there were 29,265,000 veterans, of whom 2,125,000 (7.3 percent) were 65 years of age or older.

[22] State and local governments are allowed broad use of available funds. Two of 8 suggested priority categories are "public transportation" and "social services for the poor or aged." These 2 categories accounted, respectively, for 15 percent and 3 percent of funds expended in the only period thus far reported, Jan. 1, 1972–June 30, 1973.

[23] Categorically needy; no upper income limit when deducting incurred medical expenses (medically needy).

[24] Includes potentials, and formers at State option, and those having State supplemental payments. Aged potential recipients are eligible at age 60 or older.

[25] Flexibly interpreted on a project basis but when was below 2500, not generally considered.

[26] Fiscal year 1973.

[27] Fiscal year 1975.

[28] National Mass Transportation Assistance Act of 1974.

Source: Much of the data and material for this table was initially collected by Suanne Brooks of the Atlanta regional office of the Department of Health, Education and, Welfare. This material was expanded to include a number of acts not included in that compilation.

Despite the large number of programs, however, the real usefulness of such sources is limited in ways which were emphatically described by a witness [17] at one of the AoA hearings:

> Another area of concern regarding elderly transportation programs revolves around the maze of Federal programs directed to the same end, but utilizing different means. There is a need to coordinate the multiplicity of Federal programs dealing with transportation for the elderly to prevent duplication and insure a uniformity in purpose and objective. In preparing transportation programs for the elderly one must consider: Title III, IV, VII and IX of the Older Americans Act of 1965, as amended; Titles VI and XX of the Social Security Act of 1935, as amended; Sections 3, 6, 9 and 16 (b)(2) of the Urban Mass Transportation Act of 1964, as amended; Section 147 of the Federal Aid Highway Act of 1973, as amended; appropriate sections, including Section 5, of the National Mass Transportation Assistance Act of 1974, and Title II of the Economic Opportunity Act of 1964, as amended; and of the State and Local Assistance Act (revenue sharing) of 1972.
>
> Mr. Levi concluded his remarks by stating that if there is a real desire on the part of the Federal government to achieve maximum coordination of transportation programs on a local level, there should be a Federal commitment to adopting a coordinative approach for implementation of its programs.

The "State of the Art" study said (p. 120) that really important funding for older Americans transportation projects have been provided only under Titles III and VII of the Older Americans Act and Title VI and XIX under the Social Security Act.

It added:

> It would appear that if at least the transportation funds from these four programs could be pooled, an ongoing coordinated, comprehensive network of transportation services for the elderly could be developed; funds tapped from any of the other programs listed in Table III-2 would serve to expand the transportation services that could be provided to older people. However, conflicting statutory and regulatory provisions governing the various programs which have transportation components that could be coordinated, or which could provide sources for the pooling of their respective transportation funds, tend to restrict coordination, make pooling virtually impossible, and work against continuity.

FINDINGS AND CONCLUSIONS

Legislative enactments and a Baltimore agreement on issues raised in a suit there have further committed Federal resources to the development or maintenance of adequate transportation systems for older Americans.

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[17] Mr. Peter Levi, Deputy Director of the Mid-America Regional Council, in Kansas City, Mo.

Additional action is now required within the Department of Transportation to clarify its working relationship with the Administration on Aging and—in particular—to take an affirmative and effective stance in implementing section 16(b)(2).

The Administration on Aging is due to present recommendations to the Congress in the near future on meeting the Federal commitment in this area.

This committee will await those recommendations with interest and will continue its own close scrutiny of transportation issues affecting older Americans.

CHAPTER X

VOLUNTEER AND COMMUNITY SERVICE BY THE ELDERLY

Retirement is a difficult adjustment for most persons. And at times it can be the most difficult adjustment an individual must make in a lifetime.

In our work-oriented society today, far too many older Americans are uneasy about the "shock of retirement" or the "threat of leisure."

To them, old age means neglect, despair, and deprivation. Yet, advancing age can and should provide new opportunities for activities or service and continued self-development. It can also mean a rewarding second career.

Congress has authorized several new volunteer and community service employment programs—including Foster Grandparents, RSVP, Mainstream, and the Senior Community Service Employment program—in recent years to make the later years more purposeful, rewarding, and fulfilling.

In practically every case, these activities have been enthusiastically endorsed by elderly participants and those served under the programs.

But despite the great need to step up these efforts, developments in 1974 and administrative actions early in 1975 threatened to terminate or stifle volunteer and community service employment programs for older Americans.

I. OPERATION MAINSTREAM AND TITLE IX: THE STRUGGLE CONTINUES

Operation Mainstream was created in 1965[1] as a part of the Economic Opportunity Act Amendments to provide public service job opportunities for low-income persons who would otherwise have difficulty in obtaining employment.[2] Green Thumb, administered by the National Farmers Union, was the first older workers program. It was launched in 1966. Contracts were later awarded to National Council of Senior Citizens (Senior Aides), National Council on the Aging (Senior Community Service Program), National Retired Teachers Association-American Association of Retired Persons (Senior Community Service Aides), and the U.S. Forest Service.

By any objective measurement one would choose to use, the Mainstream pilot projects have amply demonstrated the soundness of the concept of community service employment for the elderly participants and the localities served. This excellent track record provided the basis for Senator Edward Kennedy's proposal in 1970[3] to create a national senior service corps.

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[1] Public Law 89-253, Economic Opportunity Amendments of 1965, approved October 9, 1965.

[2] Authority for Mainstream is now under Title III (Special Federal Responsibilities) of the Comprehensive Employment and Training Act, Public Law 93-203, approved December 28, 1973.

After a struggle spanning 3 years, the Older American Community Service Employment Act became law[4] with a 2-year funding authorization of $160 million.

In enacting this legislation, the Congress emphasized that the national contractors should have an important role in administering the title IX Older American Community Service Employment Act. The Senate Labor and Public Welfare Committee report said:

> National organizations such as those previously named, that have acted as sponsors of the Mainstream projects would continue to be eligible to participate. In view of the success that has been achieved under the pilot program the committee is hopeful that there will be continued participation by these organizations.[5]

To a very large degree, this judgment was based upon the highly favorable independent evaluations of the national contractors. Kirschner Associates, Inc., gave this assessment:

> However, it has been demonstrated consistently in OM [Operation Mainstream] that by any standard the overall administration and operation of the program has been most effective when the national contractors are involved. . . . It is also apparent that the particular national contractors involved are appropriate for the program and have demonstrated a capability to administer effectively to the needs of both older enrollees and communities served. Thus, it is recommended that:
>
> > The proposed older worker program be continued to operate under the direction of NCSC, NCOA, NRTA, and the National Farmers Union.[6]

A. Some Limited Victories

From the very beginning the administration has resisted the establishment of a national senior service corps—in large part because of its opposition to "categorical" employment programs for older workers.

The administration, for example, has never once requested any funds for title IX, although $60 million was authorized for fiscal 1974 and $100 million for fiscal 1975. Only because of congressional insistence has the program been kept alive by appropriations of $10 million for fiscal 1974[7] and $12 million for fiscal 1975.[8]

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[3] S. 3604 (Older American Community Service Employment Act), 91st Cong., 2d Sess.

[4] Public Law 93–29, approved May 3, 1973.

[5] Senate Report 93–19, "Older Americans Comprehensive Services Amendments of 1973." Senate Report 93–19 to accompany S. 50, Older Americans Comprehensive Services Amendments, Senate Committee on Labor and Public Welfare, 93d Cong., 1st Sess., February 14, 1973, p. 21.

[6] "Final Report: National Evaluation of Operation Mainstream, A Public Service Employment Program," Kirschner Associates, Inc., December 1971, pp. 157–8.

[7] Public Law 93–245, Supplemental Appropriations Act for fiscal year 1974, approved January 3, 1974.

[8] Public Law 93–517, Labor-HEW Appropriations Act for fiscal year 1975, approved December 7, 1975.

TITLE IX.—*Enrollment positions (as of February 1975)*

Sponsor and dates of contract or grant	*Enrollment*
Green Thumb, Inc., June 28, 1974 to June 27, 1975	1,331
National Council on the Aging, June 28, 1974 to June 27, 1975	353
National Council of Senior Citizens, June 28, 1974 to June 27, 1975	743
National Retired Teachers Association—American Association of Retired Persons, June 28, 1974 to June 27, 1975	636
U.S. Forest Service, June 28, 1974 to June 27, 1975	268
Alaska, July 1, 1974 to June 30, 1975	10
Delaware, July 1, 1974 to June 30, 1975	30
Hawaii, July 1, 1974 to June 30, 1975	32
Samoa, July 1, 1974 to June 30, 1975	10
Guam, July 1, 1974 to June 30, 1975	9
Trust Territories of Pacific Islands, July 1, 1974 to June 30, 1975	19
Virgin Islands, July 1, 1974 to June 30, 1975	8
Total	3,449

Source: Department of Labor.

Today the program provides nearly 3,450 enrollment positions for older workers in a wide variety of community service activities.

Another point of contention between the Congress and the executive branch is the role of the national contractors in administering the program. Consistent with its emphasis on manpower revenue sharing, the Department of Labor opted for administration through State and local governments, with no direct role for the national contractors—except through applications on a State-by-State or locality-by-locality basis under the Comprehensive Employment and Training Act.

The Congress, on the other hand, has repeatedly called for a categorical program because older workers have been grossly under-represented in general manpower programs. During the first quarter in 1975, persons 55 and over accounted for only 2.7 percent of all individuals served under the Title I comprehensive manpower programs of CETA. For the title II public service employment program, individuals in the 55-plus age category constituted 5.2 percent of the participants.

The Congress has also stressed that national contractors should have a major role in administering title IX because of their specialized expertise and excellent record in conducting employment programs for older Americans.

However, the administration notified the national contractors on March 5, 1974, that the title IX program be administered through prime sponsors. Thus, it was necessary for the Congress to reaffirm "that the program be administered primarily through national contracts."[9] The administration relented and awarded 1-year contracts (to begin on June 27, 1974) to Green Thumb Inc., National Council on the Aging, National Council of Senior Citizens, National Retired Teachers Association-American Association of Retired Persons, and the U.S. Forest Service.

B. RESCISSION

The administration adopted another thrust—after losing on issues involving appropriations and the role of the national contractors.

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[9] House Report 93-1070 to accompany H.R. 14013, Making Supplemental Appropriations, Conference Report, 93d Cong., 2nd Sess., May 29, 1974, p. 13.

On January 30, 1975, President Ford proposed to rescind the entire fiscal 1975 appropriation of $12 million for the title IX program.

Under the new Budget and Impoundment Control Act,[10] congressional approval is necessary to ratify executive actions to withhold funds from Federal programs.

The Congress not only rejected the administration's proposed rescission but also sought additional funding. On March 12, 1975 the House of Representatives approved an emergency employment appropriations bill (H.R. 4481), which included an additional $24 million for fiscal 1975 for the title IX Older American Community Service Employment Act. The House Appropriations Committee report further directed the Department of Labor to obligate the $12 million already appropriated under the fiscal 1975 Labor-HEW Appropriations Act. [11]

C. MAINSTREAM: END OF NATIONAL CONTRACTORS?

In the same letter of March 5, 1974 (see discussion under "Some Limited Victories") the Department of Labor also said that the Mainstream older worker pilot projects were to be terminated as nationally administered programs on June 30, 1975. Under the administration's proposal, national contractors would then apply for funding with prime sponsors (primarily State and local governments) under the Comprehensive Employment and Training Act.

Only 10 of the 129 Mainstream projects—or less than 8 percent—have received even tentative commitments from CETA prime sponsors for possible continuation of the older worker programs.

Thus, several thousand aged persons are conceivably faced with the ominous prospect of losing their jobs during a period of high inflation.

In a white paper issued on January 16, 1975, the National Farmers Union, the National Council on the Aging, the National Council of Senior Citizens, and the National Retired Teachers Association-American Association of Retired Persons stated:

> At a time when the nation is reeling with the highest unemployment rate in a quarter of a century, when many older people are cutting back from two meals to one meal a day and when social service agencies will be strained to their utmost, America surely needs the help of these older people experienced in providing social services in their own communities. What this country doesn't need is more unemployed lonely old people dependent on the system for a handout.[12]

D. KENNEDY BILL TO CONTINUE TITLE IX

Senator Kennedy introduced S. 962 (on March 5, 1975) to continue the Older American Community Service Employment Act for 3 years at a $450 million authorization level: $100 million for fiscal

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[10] Public Law 93-344, approved July 12, 1974. See also p. 7 (Chapter I: "The Administration Strategy for Cutback in Aging") for more detailed discussion of the Budget and Impoundment Control Act.

[11] See Chapter I ("The Administration Strategy for Cutbacks in Aging") for further discussion of funding for Older American Community Service Employment Act.

[12] "An Appeal to Congress to Save the Senior Citizens Community Service Employment Program," prepared jointly by National Farmers Union, National Council on the Aging, National Council of Senior Citizens, and National Retired Teachers Association—American Association of Retired Persons, January 16, 1975, p. 1.

1976, $150 million for fiscal 1977 and $200 million for fiscal 1978. S. 962 also includes language to reaffirm congressional intent that the national contractors should have a major role in administering the title IX program.

Senator Kennedy described some of the outstanding achievements by the national contractors in his floor remarks:

> NRTA–AARP's senior community service employment program has compiled a remarkable record of placing 49 percent of its enrollees into unsubsidized employment. Yet the average age of enrollees remains at 66 and those enrollees include substantial numbers of minority group members, physically handicapped and even ex-offenders.
>
> The National Council on the Aging currently reports eight applicants for each available job. And they note that the programs are "designed to promote self-help, not dependency."
>
> The National Farmers Union operates the green thumb program, which concentrates its activities in rural towns and communities. Its workers strengthen existing community services, direct conservation programs, and provide special outreach services to help the aged shut-ins and the handicapped. It has been the pioneer in rural community service employment and it has produced exceptional successes in the 25 States in which it operates.
>
> The National Council of Senior Citizens has been a vigorous supporter of the title IX program and was one of the earliest innovators in the field of community service employment for older persons. They have had 1,200 formal requests from communities in all 50 States for a senior aides program—yet they cannot meet those requests with current funding.[13]

Senator Church added:

> During its 2 years of existence the title IX senior service corps has proved to be an enormously effective program, not only for the elderly participants but also the communities served.
>
> In practically every case the program has been oversubscribed. For example, the National Council of Senior Citizens' Senior Aides program has anywhere from 7 to 10 applicants for each position available.
>
> The enthusiastic acceptance of this program—as well as those sponsored by National Retired Teachers Association-American Association of Retired Persons, National Farmers Union, and the National Council on the Aging—strongly suggests that there are many low-income older Americans in virtually every community who are ready, willing, and able to serve in their localities.[14]

On April 8, 1975, the House of Representatives passed the Older Americans Amendments (H.R. 3922) which made major changes in the Older Americans Act, the Older American Community Service Employment Act, and other legislation affecting the elderly. H.R.

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[13] *Congressional Record*, March 5, 1975, p. 3099.

[14] *Congressional Record*, March 5, 1975, p. 3105.

3922 would extend the title IX program with a $700 million authorization ($100 million for fiscal 1976, $150 million for 1977, $200 million for 1978, and $250 million for 1979). If fully funded, the bill would provide 33,000 job opportunities in fiscal 1976 for low-income persons 55 or older.

The Subcommittee on Aging of the Senate Labor and Public Welfare Committee conducted a hearing on the title IX extension on March 19, 1975.

FINDINGS AND RECOMMENDATIONS

Today there are many elderly persons who are ready, willing, and able to serve in their communities. Volunteer and community service programs can be geared to their special needs, especially those who find that retirement shuts them off from purposeful activity.

What is needed, though, is a genuine commitment and working partnership on the part of the administration and Congress to expand service activities for those who want to remain active or those who must work to supplement their retirement benefits.

As necessary first steps toward implementing this goal, the committee recommends the following:

The Older American Community Service Employment Act should be extended.

The national contractors—because of their high-level expertise concering problems confronting older workers—should continue to have a major role in administering Mainstream and the Older American Community Service Employment program.

Adequate funding should be provided to permit the sound growth of Mainstream, the Older American Community Service Employment Act, Foster Grandparents, Senior Companions, RSVP, the Action Corps of Executives, and Service Corps of Retired Executives.

Careful consideration should be given by the legislative and executive branches to the appropriate placement of Foster Grandparents and RSVP when the Older Americans Act is acted upon by the Congress.

CHAPTER XI

1976—MIDWAY BETWEEN WHITE HOUSE CONFERENCES ON AGING

One theme heard again and again during the preparations and early aftermath of the 1971 White House Conference on Aging was that the conference was just one event in a continuing effort dedicated to better lives for older Americans.[1]

Much the same point was made in a report [2] which appeared almost two years later and said on behalf of the Administration then in power:

> It is clear that this report cannot properly be viewed as the end of the process. The work must—and will—go on. It must go on in order, as the President has urged, to make ours a time of which can be said, "the glory of the present age is that in it men and women can grow old" and can do so with grace and pride and dignity, honored and useful citizens of the land they did so much to build.

A Post-Conference Board emphatically agreed with the need for continuing action in their own part of the same report. They also called for action going considerably beyond the Administration's position in important areas.

Whatever the 1973 reports called for, it is clear that the field of aging—even the part of it which can properly be related to governmental concern—is so fast-changing and so directly influenced by social and economic forces of the day, that no set of recommendations or policies will remain fully valid for very long.

This is particularly true during a period in which the United States faces inflation, recession, new questions about the Federal role in maintaining the well-being of its citizens, vast changes on the international scene, and even self-searching about the very goals of our nation.

Recent events related to our Social Security system (see chapter II) provide an example of swift changes which have occurred since 1971. Benefits have been raised significantly; a new supplementary payments program is administered through the Social Security Administration; automatic cost-of-living adjustments are now required by law; and inflation and recession are putting new strains on the overall system.

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[1] For full information on the background, organization, and recommendations of the Conference (Nov. 23–Dec. 2, 1971), see *The 1971 Conference on Aging: Toward A National Policy on Aging*, Vol. I–II Stock No. 1762–0069, For Sale, Superintendent of Documents, U.S. Govt. Ptg. Off., Wash., D.C. 20402. Price $6.75 per 2-volume set. Sold in sets only. For an interpretation of Conference recommendations and early Congressional and Administration response, see *Developments in Aging: 1971 and January–March 1972*, Annual Report of the U.S. Senate Special Committee on Aging, pp. 1–81.

[2] *Post-White House Conference on Aging Reports: 1973*, containing *Towards a New Attitude on Aging—April 1973: A Report on the Administration's Continuing Response to the Recommendations of the Delegates to the 1971 White House Conference on Aging*, together with *Final Report of the Post–Conference Board of the 1971 White House Conference on Aging—June 1973*, prepared for the Subcommittee on Aging of the Committee on Labor and Public Welfare and the Special Committee on Aging, U.S. Senate, September 1973.

In short, in the area of retirement income alone, events and trends that could not have been anticipated have indeed happened, sometimes in combination that surprised even the most informed onlookers.

Much the same is true in other areas related to aging: progress is occurring, but so are new problems. And so are new combinations of both.

Next year, 1976, will be the Bicentennial of this Nation.

It will also be the fifth anniversary year of the 1971 White House Conference on Aging. If the present pattern continues—a White House Conference on Aging every 10 years—then 1976 will be mid-way between the one held in 1971 and the one likely to be held in 1981.

The Senate Committee on Aging—well aware of the pressing need for action on so many fronts related to aging—would be reluctant to divert resources and human energies into unrewarding or redundant activities during a year as momentous as 1976 should be.

But the committee is also aware of the need for measuring progress—and evaluating new demands—that have occurred since 1971.

Therefore, to augment the suggestion made by committee Chairman Frank Church in the preface to this report, the committee asks for letters or other communication in response to these questions:

—Should legislation be introduced—or the administration be requested by the Congress through this committee—to call for a White House Conference on Aging in 1976 simiiar to the 1971 Conference in terms of subject matter and general approach, but on a much-reduced scale?

—Or should a conference be held covering the gamut of subjects of greatest Federal concern, without any attempt to duplicate—even on a reduced scale—the format and subjects of special emphasis chosen for the 1971 Conference?

—Or perhaps one subject of overriding immediacy or importance could be chosen for intensive attention in 1976. Senators Moss and Church, for example, have already introduced legislation calling for a White House Conference on Long-Term Care and offering $500,000 for this purpose. There is much to be said for long-term care as an appropriate subject for intensive attention mid-way between White House Conferences on Aging. Important issues related to overall health resources and pervasive attitudes toward aging would be involved, as would the overall income situation of the elderly. In addition, momentum for genuine reform in the nursing home field is now at what may be an historic high; a conference next year would be timely and possibly a watershed in gerontological history.

—On the other hand, perhaps a similar case could be made for other subjects. Among them, the attempt to define "adequacy" in terms of retirement income and in terms of the Federal commitment toward that end; special needs of the elderly in any national health insurance program (unless resolved by that time); issues related to the delivery of services to the elderly, et cetera.

RECOMMENDATION

The Senate Committee on Aging wishes to make a recommendation in 1975 for a Mid-Way White House Conference on Aging in 1976. It would appear that little would be gained by conducting a miniature version of the 1971 Conference; it would seem, instead, it should be directed at one key issue related to many others.

However, the committee seeks advice on this matter before making its recommendation.

Therefore, it solicits letters or other forms of correspondence,[3] by July 20, before deciding on what steps, if any, to take.

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[3] Write to Senator Church, chairman, U.S. Senate Committee on Aging, Room G-225, Dirksen Senate Office Building, Washington, D.C. 20510.

MINORITY VIEWS OF MESSRS. FONG, HANSEN, BROOKE, PERCY, BEALL, DOMENICI, BROCK, AND BARTLETT

This committee, as discussed in detail elsewhere in this report, has emphasized a wide range of special needs among older Americans. They involve challenges for action including those related to:

- Solid reassurance that the OASDI cash benefits program under social security will always be a reliable source of retirement income.
- Health maintenance and preventive medical care.
- Adequate treatment of chronic illness, in both the home and institutional settings.
- Decent minimum income standards in the SSI program.
- Equitable tax relief at all levels of government, including updating of the Federal retirement income tax credit.
- Expansion and improvement in private pension plans.
- Housing with choices suitable to varying individual needs.
- New concepts about retirement with increased job opportunities for persons past 65 who want to work full-time or part-time.
- Improved nutrition services and programs.
- More effective social services for the elderly.
- Transportation services capable of giving older persons the mobility necessary to satisfy personal needs and prevent isolation and loneliness.

With stimulus from the Older Americans Act, extension of which we strongly support, progress has been made in imaginative new programs for older persons, with enthusiastic response from those receiving the services. Limited funds now available for such purposes, however, permit reaching only a small percentage of those who might benefit. *Ultimate full success of these efforts will require wider public recognition of their merit.*

NEW CONCERNS ABOUT OASDI FINANCING AND NURSING HOMES

The major issues of importance to all Americans, old and young, which have come to the forefront during the past year, were:

1. Growing public concern about the ability of the social security cash benefits program, OASDI (Old-Age, Survivors, and Disability Insurance), to meet its financial obligations to beneficiaries.

It has serious significance for older Americans because they are the beneficiaries and to young Americans because they are the contributing taxpayers and future beneficiaries.

2. New revelations of scandalous conditions in some of America's nursing homes.

The Subcommittee on Long-Term Care has been aggressive in calling attention to serious shortcomings in efforts to control nursing home abuses. Its work has been carried out with full support of the entire committee.

Deficiencies in long-term care for older Americans, epitomized by but not exclusive to—the nursing home problem, demand serious attention. *Even as we push for immediate action to eliminate fraud, excessive costs, and mistreatment of patients whenever they occur in nursing homes, the Nation must face up to root causes of inadequacies in all long-term care for the elderly and to how such services may best be delivered.*

Since the Long-Term Care Subcommittee's work is discussed at length in chapter IV of this report, and its findings are being publicized widely through a series of reports being issued at approximately 1 to 2 month intervals, it is unnecessary here to do more than re-emphasize our view that decent, safe, adequate nursing home care, without excessive profiteering and fraud, is a must.

While a relatively small percentage of the elderly are in nursing homes, they are persons who need and deserve maximum consideration from our society on humanitarian grounds.

FIRST PRIORITY FOR OLDER AMERICANS: STRENGTHENING SOCIAL SECURITY

Because it is of first priority to older Americans, Congress should act without delay to solve the financial problem faced by social security's OASDI (Old-Age, Survivors, and Disability Insurance) program.

No legislative action is of greater importance than positive efforts to strengthen OASDI as the primary source of retirement income.

Older Americans need reassurances now, which go beyond mere words, that this cash benefits program will continue to provide the payments which they have been led to expect.

Action must be taken now to eliminate both immediate and long-term deficits facing OASDI.

Such corrective action is also important for those who have not yet retired. As the workers whose taxes now support OASDI, they must be convinced that they will receive their benefits in the future, no matter how many years ahead that may be.

Steps already initiated by the Senate Committee on Finance and the House Committee on Ways and Means show recognition of the high priority which must be given to the OASDI financial problem. Efforts aimed at its solution should receive full support from the Congress.

OASDI Questions On Which Congress Must Act Now

OASDI is too important to the American people to be given casual treatment by the Congress at any time. We cannot afford to approach it on a haphazard or piecemeal basis. Our actions should always be taken with recognition of the serious implications they may have on our whole socio-economic system and the long-range needs which must be met.

At this time of crisis, which re-emphasizes the extreme care which must be used in any amendment to the Social Security Act, we should look seriously at the questions which now trouble the people about OASDI.

The major questions today include:

- How can the social security cash benefits program be made financially sound?
- What changes in revenue and/or benefits should be considered?
- Should there be a return to the original purposes of the social security system?
- Have we exceeded reasonable performance limits for OASDI by trying to do too much for too many too fast?
- Where will the obviously necessary additional money come from?
- Will the workers accept increases in payroll taxes big enough to pay benefits at current real dollar levels of today and tomorrow?
- Should the Nation use money from general revenues to meet fund shortages? How much should general revenues be called upon for this purpose? What effect would this have on income taxes required from young and old? On indirect taxes paid on purchases they make?
- Are there other alternatives which could meet the OASDI financial crisis—in both its short-term and long-term dimensions?
- How do answers to these and similar questions inter-relate with other legislative proposals—such as those for national health insurance?

As Congress and the people consider such questions, it is appropriate to look at the questions already in the public's mind. How immediate and serious are OASDI's financial problems? How did the problems come about? What solutions have been proposed?

HOW IMMEDIATE AND SERIOUS ARE OASDI'S PROBLEMS?

Immediacy of the problem is underscored by estimates in the 1975 annual report of the Board of Trustees of the Federal Old-Age, Survivors Insurance and Disability Insurance Trust Funds that the combined *deficits* of outgo over income for OASDI operations in 1976 will total $5.8 billion.

If no corrective action is taken, this excess of annual outgo over annual income will reach the $6.8 billion level by 1979, and current assets in the combined Old-Age and Survivors Insurance Trust Fund and the Disability Insurance Trust Fund will be exhausted by 1981.

Although originally promoted with the idea that a large reserve fund was to be created from the employer/employee contributions so that it would provide interest earnings to meet a large part of the benefit cost, we have now come to the point where in 1981 there will be no assets in the fund, and contributions will not be sufficient to meet the payments required. In fact, the income in 1976 will be $5.8 billion less than payments, and in 1979 will be $6.8 billion less than payments.

As the expected reserve did not materialize, then it became the accepted view that assets at the beginning of each year should roughly equal expected OASDI pay-out obligations for the year to follow.

With this view in mind, whatever current reserve level is regarded as acceptable, the need for immediate action is shown by the latest available estimates from the Social Security Administration for the next several years as to the probable percentage relationship of OASDI *assets at year's beginning to expected outgo* in benefits and administrative expenses for that year. For calendar year 1975, estimated assets in the funds represent 66 percent of expected outgo;

	Percent
for 1976	55
for 1977	42
for 1978	32
for 1979	24
for 1980	16

and in 1981 both funds will be exhausted and unable to meet their commitments.

The foregoing are combined figures for Old-Age and Survivors Insurance and Disability Insurance although there is a separate trust fund for each. Predictions for the Disability Insurance fund alone show even more dramatic changes in reserve levels. This can only be explained as being the result of serious miscalculations about the emerging experience for disability benefits. For the beginning of calendar year 1975, expected assets were 93 percent of projected outgo;

	Percent
for 1976	73
for 1977	51
for 1978	32
for 1979	17

and in 1980, the fund will be exhausted.

At the point where funds are exhausted, the law requires cessations in benefit payments.

THE GREATER LONG-TERM OASDI PROBLEM

Long-term projections of OASDI operations show even greater problems in social security financing.

The differences in the magnitude of predicted dollar shortages in OASDI depend on differences in assumptions made by various experts as to probable rates of inflation and wage level increases on the one hand, and, on the other, what will be future trends in retirement patterns and the birth rate.

The general range of estimates, however, indicates that unless corrective action is taken, the deficit in terms of present dollars will be somewhere between $1.3 trillion and $2.4 trillion over the next 75 years.

Another indication of the problem's magnitude is the tax increase which would be necessary, if no other changes are made in the law, to prevent such deficits. The 1975 OASDI Trustees report, using assumptions that some believe are too optimistic, has indicated that the combined social security taxes for OASDI on employee and employer would have to rise from the current 9.9 percent of payroll to over 20 percent. This is in addition to the tax for the Hospital Insurance portion of medicare.

According to the 1975 Board of Trustees report, the *annual* average deficit over the next 25-year period (1975–1999) is estimated to be 1.26 percent of payroll. When applied to the current taxable payroll of approximately $700 billion, this is a deficit of $8.8 billion per year.

The average annual deficit over the second 25-year period (2000–2024) is estimated by the Trustees to be 4.10 percent of taxable payroll. If this percentage were applied to the present payroll the annual deficit would be $28.7 billion. Over the third 25-year period (2025–2049) the average deficit estimated by the Trustees is 10.19 percent. Again applying this to the present payroll, the annual deficit would be $71.3 billion.

Payrolls in both the second and third 25-year periods will obviously be vastly increased and therefore the deficits will be proportionately greater.

HOW DID OASDI'S PROBLEMS COME ABOUT?

The truth of the matter is that we in Congress have acted on social security proposals in many cases without full understanding or concern for their potential future implications. In its eagerness to make OASDI more helpful to individual beneficiaries, Congress too often has been willing to accept the most optimistic predictions about income and outgo of the system. We have failed to apply the conservative principles of sound business judgment which should be our first thought for so important a program as the social security system.

The Congress has failed to vote taxes commensurate with increases Congress voted in benefits. With the 8 percent cost of living increase scheduled to take effect with the July 1 payments, there will have been an increase in OASDI benefits from 1970 through 1975 of 82 percent. During the same period, the cost of living rose approximately 35 percent.

In our actions on a program aimed at helping meet the contingencies of life faced by individuals, we have ignored contingencies, such as sharp inflation and recession, which have had serious repercussions for the program itself.

The failure of social security tax income to equal outgo for OASDI and medicare this year and during the years immediately ahead is in part a direct result of the continuing inflationary spiral. The deficits have been exacerbated by the recession which has caused revenues to the social security system to fall below previous expectations.

The even more sizable deficits predicted by experts for OASDI during the next 50 to 75 years and beyond, unless changes are made, are primarily due to new predictions regarding three major factors:

1. Inflation and wage level expectations;
2. Anticipated continued early retirement trends; and
3. Predictions that there will be little or no growth in the total population because of low birth rates and that the percentage of the elderly in the population will rise substantially.

A part of the predicted near-term and long-term deficits is attributable to a flaw in provisions for automatic cost of living increases for OASDI beneficiaries which has the effect of giving what might be described as a double increase in prospective benefits to those who have not yet retired. At present, the benefit formula for those who have not yet retired is increased on the basis of the cost-of-living increases. *It also goes up because of wage increases.*

The 1974–1975 Advisory Council on Social Security has recommended retention of the automatic living cost increases in OASDI for retirees, present and future. We agree.

The Council has recommended that this procedure as applied to the benefit formula used for those still in the work force be eliminated, by limiting changes in the formula for those currently working to changes based on average increases in wages. This approach deserves careful consideration.

Even with correction of inequity in the cost-of-living adjustments, there will still remain serious financial difficulties.

Basic to the long-range financial problems of OASDI, as distinguished from the serious and growing deficits in the immediate 5 years ahead, are the probabilities that, within 40 years, current retirement trends and low birth-rates will combine to reduce the ratio of workers paying social security taxes from three for each beneficiary to two.

The average beneficiary today receives about $1,945 per year. This means that the combined tax deducted from the two average employee's paychecks each year, and paid for them by their employers would have to equal $972.50 to pay for this one beneficiary. The 1974 average combined employee-employer tax was $583 for each taxpayer. Thus for two average workers the combined taxes equaled $1,166, producing a deficit of $779 per year.

The birth-rate factor for several years has been at a level which could result in little growth in the national population and is expected to continue at such levels for at least several years. The certainty that there will be far fewer persons below the age of 65 in proportion to those above 65 cannot be ignored.

It raises serious questions as to whether or not current retirement patterns—which have shown a trend toward earlier and earlier retirement ages—can be continued.

Note was taken of this question by the 1974–75 Advisory Council on Social Security, in its recent report, when it suggested that at some time in the distant future the Congress should consider the possibility of raising the age for full retirement benefits under OASDI from 65 to 68.

HOW CAN OASDI'S FINANCIAL PROBLEMS BE MET?

Current large deficits in OASDI demand that Congress act without delay to bring the program's income into balance with its outgo.

Simultaneously we should begin now a review of steps necessary to prevent the even larger deficits predicted for the next 50 to 75 years.

While final determinations in these matters is not the responsibility of the Special Committee on Aging, it is appropriate here to look at some of the alternatives which have been proposed. As they are considered in the weeks ahead by Congressional committees with legislative responsibility for social security, we urge that their impact on the lives of all American citizens and the Nation's whole economy be given most careful consideration.

As discussed earlier in this statement, one action is to correct the flaw in current provisions for automatic cost-of-living adjustments in payments to OASDI beneficiaries. While providing that the benefit formula for those who are now working shall reflect both rising average wage levels and increases in individual earnings, it appears fiscally necessary that adjustments in payments based on cost-of-living increases be limited to retirees and others actually drawing OASDI benefits. This elimination of "doubled" increases for those still in the work force would be fair to all participants in the system.

It was never intended that cost-of-living adjustments should be applied independently to the benefit schedule for those who are still working. Their increases should be taken care of solely on the basis of rising wages.

Such action along the lines proposed by the 1974-75 Advisory Council on Social Security and endorsed in principle by the OASDI Trustees, could offer a response to criticism of the rationality of the law's present language on automatic adjustments voiced earlier in the year by the Finance Committee's special Panel on Social Security Financing.

After indicating that failure to correct the double-impact effect of the present provision can produce patterns of replacement ratios inconsistent with the generally understood purpose of the social security system, the panel said: "Unless material changes are made in the benefit formula, Congress will not have the appropriate control over the reasonableness and consistency of benefits and it will be difficult, if not impossible, to finance the system on a satisfactory actuarial basis."

Depending on the precise way the inequity is corrected in the benefit formula as it relates to cost-of-living increases and on actual future experience in wage levels and inflation, such action could cut long-range OASDI deficits by from 20 to 50 percent.

Even so, the remaining prospective OASDI deficits will be huge. They also require prompt steps for provision of more OASDI revenue within the next year or two at the latest.

If such revenue comes solely from increases in social security tax rates, it has been indicated that an increase of one-half of one percent of payroll in both the tax on employer and the tax on employee would be needed in 1976 or, at the latest, 1977. A second tax increase of one-half of one percent on employer and employee will also be required within the next five years.

With these two increases, the combined social security taxes on employer and employee for OASDI and the Hospital Insurance portion of medicare would reach 14.6 percent of wages subject to social security taxes in the early 1980's.

Numerous alternatives to straight increases in tax rates have been suggested. They include raising the maximum wage on which social security taxes are levied, use of general revenues, and combination of such steps with tax rate increases.

However the funds are raised, the fact remains that the money must be raised somehow.

The Nation must also give serious and immediate thought to a review of current retirement patterns. This should relate to effects of continued trends on both OASDI's ability to continue as a program acceptable to the workers who pay the taxes on which it depends as well as to how current practices affect the lives of individual older Americans. This becomes critically important with the prospect that, unless new approaches are developed, within 40 years the number of workers supporting each OASDI beneficiary will fall from more than three workers for one beneficiary to less than two for one. This we see as an impossible burden for those who are working.

Whatever is done to meet the problems, both immediate and long-term, it is essential that Congress act now.

CONTINUOUS SOCIAL SECURITY OVERVIEW NEEDED

Trustees for the Social Security Trust Funds, the 1974–75 Advisory Council on Social Security and the Senate Committee on Finance Panel on Social Security Financing have indicated that more study of social security and its problems is needed.

The logical conclusion to be drawn from any of the three reports is that there should be a continuous overview of social security by a permanent, continuing council or commission with no other responsibilities.

The 1974–75 Advisory Council said, in part:

> Major aspects of social security that deserve attention, but that the Council did not have time to analyze thoroughly, included: full reserve funding vs. current cost financing; the effects of social security on productivity, capital formation, and private savings; the relationship between private pensions and social security; and the appropriate size of the trust funds. . . . Comprehensive study of these and related issues should be conducted by a full-time nongovernment body. . . .

The Committee on Finance Panel on Social Security Financing said:

> In view of limitation of time, the Panel concentrated its study on the structure of the retirement benefits and its impact on the financing of the program. Other benefit formulas such as survivor benefits may deserve an equally thorough study.

These observations reinforce the validity of the Minority recommendation in the Special Committee on Aging Report filed May 5, 1972, and reaffirmed in Minority views during the 93rd Congress, that there should be a review agency for social security capable of serving a continuing ombudsman role for the people.

Specifically, the recommendation was that the Congress enact legislation to create a permanent, independent, bi-partisan commission to maintain constant surveillance of Social Security, to provide the President, the Congress and the people with sufficient information to give maximum assurance that all decisions related to Social Security are well taken. Such a commission should have responsibility also for constant overview as to the Social Security system's adequacy and performance in meeting needs of the country and might well include a mechanism for adjustment of grievances against the system.

One way of implementing this would be through enactment of S. J. Res. 5, a Joint Resolution to establish a National Social Security Commission, introduced early in the current session of Congress by Senators Fong, Fannin, Tower, Thurmond, Brock, Domenici, and Hansen.

Responsibilities of the National Social Security Commission would be the same as those now assigned by law to the Advisory Council on Social Security. Operational and structural changes to be made would be as follows:

1. Members of the Commission, instead of being named by the Secretary of Health, Education, and Welfare, would be named on a bi-

partisan basis, with appointment power divided between the President, the President pro tem of the Senate and the Speaker of the House of Representatives.

2. The Commission would be permanent, functioning on a continuing basis with regular reports to Congress and the people, in contrast to current provisions for appointment of a new Advisory Council every 4 years with a tenure of approximately 1½ years.

3. The Commission would have its own professional staff rather than having to rely on the Social Security Administration.

The National Social Security Commission would be an appropriate instrument for the numerous studies suggested by the temporary panels which have worked on various aspects of social security.

OLDER AMERICA'S ENEMY NO. 1 IS STILL INFLATION

While the seriousness of the current and future financial crisis facing social security's OASDI program has, because of its immediacy, been given primary emphasis in this statement, we must repeat our long-held view that inflation is the most serious economic problem of the aging. In both universality and severity of impact, it is still the No. 1 public enemy of older Americans.

Inflation has been a major factor in OASDI's financial difficulties.

Inflation reduces the effectiveness of private pension plans.

Inflation creates new property tax burdens for home owners.

Inflation erodes the value of personal savings accumulated over the years.

In short, there are few problems faced by most older Americans which are not exacerbated by the cost-of-living spiral.

As we reiterate our belief in the importance of a stable American dollar, we are fully aware that there may be moments in our Nation's history when the pay-as-we-go approach to the Federal budget—an essential to control of inflation—will not be in the best interests of the people.

Today's war against recession, as surely as previous military wars to protect our shores, has necessitated unusual action by the Government. But our previous and continuing support of legitimate emergency measures to prevent needless hardship by our people during this difficult period in our country's life, is not an endorsement of long-term deficit policies such as those in recent years which contributed so sharply to the economic problems America now faces.

We affirm the position taken in Minority Views of this committee since the inflationary spiral became an obviously growing problem in 1966, that long-range national spending patterns must aim at avoiding unmanageable rises in living costs. At no time can this country afford the kinds of waste and unjustifiable fiscal irresponsibility which has often characterized Federal spending during the past decade.

SUMMARY

Of the many problems facing older Americans, their need for income on which they can rely to buy the necessities of life is the most serious.

Since social security's OASDI cash benefits program is the most important source of income for retirees, it is imperative that Congress take prompt action to meet the serious financial crisis facing OASDI.

OASDI is in trouble. Outgo in excess of income will be $5.8 billion in 1976

This annual OASDI deficit will increase each year to the point that assets will be exhausted by 1981. This is the short term problem.

The serious dimensions of the long term OASDI financial problem—unless corrective action is taken—are shown by predictions that deficits will amount to from $1.3 trillion to over $2.4 trillion over the next 75 years.

As inflation and expected continuous increases in benefits due to automatic adjustments—which now have a double increase effect for those not yet retired—and the current trend toward early retirement combined with low birth rates—which will result in the ratio of workers to OASDI beneficiaries falling from the current level of 3 to 1 to 2 to 1 within 40 years—will produce tremendous deficits, it is imperative that Congress act immediately to assure a viable, sound social security system for present and future beneficiaries.

These questions must be answered:

Where will the money come from?

If by increased taxes on employees and employers, how much of an increase?

If by general revenues, how much?

If by both increased social security taxes and general revenues, what is to be the division?

Hiram L. Fong,
Clifford P. Hansen,
Edward W. Brooke,
Charles H. Percy,
J. Glenn Beall, Jr.,
Pete V. Domenici,
Bill Brock,
Dewey F. Bartlett.

SUPPLEMENTAL VIEWS OF MR. CHARLES H. PERCY ON SOCIAL SECURITY FINANCING

I have been deeply concerned at the verbal battle waged during the last year over the financial soundness of the social security system. Now that the 1975 Report of the OASDI Board of Trustees has confirmed the projection of financial problems made by the Board in its 1974 Report and by the Advisory Committee on Social Security and the Panel on Social Security Financing appointed by the Senate Finance Committee, hopefully we can rise above the din and work together to bring order to this system.

It is as fiscally irresponsible and cruel to the elderly to ignore reality and leave these problems to future generations as it is to declare that the system will soon collapse and do nothing to prevent it.

The social security system will not collapse. Future generations will not deny earned benefits to the retired. However, it is evident that the system cannot continue to be self supporting under the present contribution and benefit formulas. The immediate gap between income and outgo is small compared with the deficit projected for the twenty-first century. We must avoid the temptation to deal with the short-term problem with stop gap measures and leave long-term solutions to those who will be responsible for the system at that time. To do so could not help but result in serious economic dislocations and hardship.

Two main factors must be taken into account in improving the social security system. Its economic impact must be fair and manageable for employers and workers on the one hand and fair and adequate for retirees on the other. It must also be financially sound over the long term, so that neither a massive infusion of funds nor a reduction in benefits is ever necessary. If we take corrective action now, I believe it is possible to meet both these goals.

In their 1975 Report, the Board of Trustees estimates that the equivalent of an additional 1.26 percent payroll tax will be necessary to meet the costs of the social security system through 1999. After that, costs are estimated to increase more dramatically, and the equivalent of a 10.19 increase in the payroll tax will be necessary for the years 2025 to 2049.

The difference between these estimates and those made earlier this year point out the very significant difference small variances in economic and demographic assumptions can make. I believe the most sensible course at this time is for the Congress to enact those changes in the social security system which will assure its enduring effectiveness. By 1990, we will know for certain the ratio between workers and retirees during the first half of the 21st century—the most important variable in today's cost projections—and have a better view of the long-term relationship between prices and wages—also a major variable. We will then be able to plan ahead accordingly.

The most important change we should consider making in the social security system today is to "decouple" social security benefit levels. This recommendation has been made by virtually everyone who has studied the system during the last year and Congress should begin consideration of it immediately. Under the present system, a worker who retires 20 years from now will receive a benefit which will directly reflect not only the compounded 20 year increase in the consumer price index, but all wage increases received during the period. For a worker retiring in the year 2050, this could result in a monthly social security benefit 60 percent higher than the worker's average pre-retirement wage. Coupled with a spouse's benefit, the retired couple's benefit would be nearly 150 percent higher than the worker's average pre-retirement wage. While this problem is not critical to the financial integrity of the system today, it plays a major part in the estimated long-term deficit. "Decoupling" the system by basing retirement benefits on a worker's average monthly wage, increased, or "indexed," to reflect average wage increases for all workers during that period, and providing cost of living increases only after retirement, would correct this problem. The Board estimates that this step would reduce the amount of additional funding needed to the equivalent of 1.05 percent of taxable payroll for the years 1975–1999 and to 4.66 percent of taxable payroll for the years 2025 to 2049.

Obviously this one step would significantly reduce the long-term financing problem. Other benefit and financing suggestions have been made which would close the rest of the short-term gap and lay the basis for an equitable and potentially fiscally sound system for the next generation of retirees. The Congress should begin this study immediately and take action soon to preserve the integrity of our Social Security System.

CHARLES H. PERCY.

SUPPLEMENTAL VIEWS OF MESSRS. BEALL, BROOKE, AND DOMENICI

The Minority Report, which we have signed, reflects a generally gloomy picture of the long and short range financial viability of the Social Security system. This Report closely parallels the findings of the Social Security Trustees.

But it is important to reiterate several important points:

1. *The Congress will not allow the financial shortfall in the trust fund to jeopardize the social security benefits of current or future recipients.* The problems are difficult but they are not insoluble. Last year the Congress finally came to grips with and solved the financial problems of the Railroad Retirement program. In addition, the 93rd Congress enacted the Pension Reform Act of 1974 which will begin to bring order out of the chaos that has plagued private pension systems.
2. The Congress has tended to enact Social Security legislation in a piecemeal fashion. Some of the current problems confronting the trust fund are clearly the result of congressional action or inaction. The present difficulties provide the Congress with an opportunity to review the entire Social Security system so as to restructure the tax rates and benefit schedules in such a way as to meet both the long and short range needs of the program.

The Congress must rise to the current challenge and restructure this program so as to insure the future viability of this vital link in the income support system for senior citizens. A comprehensive social security program, in cooperation with private pensions and other federal and state retirement benefit programs, can help to provide senior citizens with an adequate retirement income that will enable them to live in dignity and independence.

J. Glenn Beall, Jr.,
Edward W. Brooke,
Pete V. Domenici.

APPENDIXES

Appendix 1

ANALYSIS OF EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (PUBLIC LAW 93–406)[1]

New protections and guarantees for employees covered by private pension and welfare plans and for their beneficiaries are provided in the Employee Retirement Income Security Act of 1974 (Public Law 93–406). Enactment of the new reforms culminated more than 5 years of effort by the U.S. Senate Aging and Labor Committees.

About 35 million persons covered by private employee benefit plans are affected by the new law. Responsibilities for implementing the new provisions are assigned to the U.S. Department of Labor, the Internal Revenue Service, and the newly created Pension Benefit Guarantee Corporation. Attached appendix 1 describes the federal administration.

The inadequacy of existing law and the obvious need for reform was recognized by the Senate in the last three sessions of Congress.

Beginning with a series of studies and hearings on the "Economics of Aging," the U.S. Senate Special Committee on Aging focused national attention on pension reform issues. These studies revealed that while Social Security was still the economic mainstay for the vast majority of older Americans that many of their number had a vital stake in the employee benefit plans of private corporations.

The road to a secure retirement in the private system is paved with great expectations. Just over 4 million American workers were covered by private plans in 1940 with assets totaling $2.4 billion. Today more than 30 million persons are employed with firms having a private plan. Assets held in trust for these employees now exceed $130 billion.

Despite this enormous growth, however, about half the employees in private industry are still not covered by any plan and many plans were found to have restrictive age and service requirements which resulted in the exclusion of many employees.

Legislative History

In 1970, 1971, and 1972, the Senate adopted resolutions mandating the Subcommittee on Labor to conduct an investigation of pension and welfare funds in the United States. On each occasion, the Senate directed the Subcommittee on Labor to place "special emphasis" on the need for protection of the 35 million workers covered by the private pension system.

A major segment of this investigation included a statistical survey of 1400 plans drawn from a sample of plans on file at the Department of Labor. To be sure, many excellent plans were found to be providing the security they promised. But analysis of the fine print of many pension contracts produced some disturbing results.

It revealed provisions which severely restricted eligibility for benefits, provisions which limited the employer's funding commitment and provisions which permitted questionable investment practices. A pattern of lost benefits was identified. Many participants had simply been unable to qualify for any benefits, while others, who had managed to acquire a vested right to their pension credit, lost their benefits when the plan was terminated without adequate funds. Approximately, 1,200 terminations occurred in 1972 with about 8,500 participants losing vested benefits with a value of $35 million.

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[1] The Senate Committee on Aging is grateful to Mr. Michael Schoenberger for writing this report on the pension reform bill. Mr. Schoenberger, a research assistant with the Senate Committee on Labor and Public Welfare, worked on the bill before enactment. Since then, he has been named a member of Joint Pension Study Group, a unit comprising staff members from the four Congressional units which considered the legislation.

The Subcommittee on Labor concluded that these losses should be prevented by the adoption of comprehensive nationwide standards for the administration of the private pension and welfare plans. Accordingly, it made recommendations for comprehensive reform in the 92nd Congress.

These recommendations were embodied in a major pension reform measure (S. 4) introduced by Senators Williams and Javits in the early days of the 93d Congress. As a former Chairman of the Senate Aging Committee and now present Chairman of the Senate Labor Committee, Senator Harrison A. Williams, Jr., had a long-standing commitment to comprehensive reform. Senator Williams had directed the pension study from its inception.

The Williams-Javits legislation became the principal reform vehicle in the Senate and its principles were embodied in the measure which later passed by a unanimous Senate vote.

Later several tax reform measures were incorporated into the final legislative product which was signed by the President on Labor Day as the Employee Retirement Income Security Act of 1974 (ERISA).

In broad outline, ERISA was designed to:

1. Encourage the growth of private pension and welfare plans,
2. Insure that those who participate in such plans do not lose their benefits as a result of unduly restrictive eligibility provisions or by the failure of the plan to accumulate and retain sufficient funds to meet its obligations and.
3. Provide greater equity in the tax treatment of private retirement savings among the taxpayer groups involved.

MAJOR PROVISIONS

COVERAGE AND PARTICIPATION

Government plans, railroad retirement plans, and church plans were not covered by the provisions of ERISA. This regulation was designed from its inception specifically for the plans of private corporations.

Participation refers to the right of employees to have their work counted toward the earning of vested benefits. The new law requires that a worker who has reached age 25 and has earned at least one year of service must be permitted to participate if his employer has a plan.

VESTING

Vesting is the heart of the new law and it will probably have the most significant impact. This term refers to right of the employee to acquire a legal claim to his pension credit after working a reasonable period under the coverage of the plan. Prior to the new law, each pension plan could have whatever vesting schedule it chose.

ERISA requires the plan to adopt one of the three alternative standards which require:

1. Full vesting after 10 years of service, or
2. 25 percent vesting after 5 years of service gradually increasing to full vesting after 15 years of service or
3. A rule of 45 under which employees with 5 years of service begin to vest when their age and service totals 45.

SURVIVOR BENEFITS

If the retirement plan provides benefits in the form of an annuity, as most do, it will now be required to offer a joint and survivor option to married plan participants. A joint and survivor annuity pays benefits to the retired worker and spouse so long as they are both alive and then continues benefits, sometimes at a lower level, to the survivor if one spouse dies.

PLAN TERMINATION INSURANCE

Title IV of the Act establishes a new federal insurance program to ensure that employees who participate in private pension plans have guaranteed pension benefits even if their plan should prematurely terminate without adequate assets on hand. Monthly vested benefits are guaranteed up to certain limits ($750 a month). Based on past performance, approximately 1200 terminations can be expected annually.

The insurance program is now processing 500 terminations which have occurred since enactment. More than $25 million in premiums have been collected to meet these claims.

FIDUCIARY STANDARDS

Under prior law, trustees of employee benefit plans were required to administer the plan so as to protect the financial interests of participants. The precise content of these general duties had never been delineated legislatively until ERISA. Under the new law, trustees and other fiduciaries must administer the plan solely in the interest of participants and beneficiaries. Also they are held to strict standard of care in the investment of plan funds.

INDIVIDUAL RETIREMENT ACCOUNTS

Individuals not covered by either a government or private pension plan are allowed a tax deduction for contributions to their own individual retirement savings account. For that half of the work force not covered by a plan, the Act permits the new (IRA) Account as a means of retirement savings. Deductions for contributions of up to $1,500 annually are allowed.

KEOGH PLANS

Deductions for contributions made to the plans of the self-employed were increased from a maximum of $2,500 to $7,500 per year.

REPORTING AND DISCLOSURE

The new Act replaces and extends the disclosure requirements of prior law. Every pension plan will be required to furnish each worker with a summary plan description. It is required to be written in plain understandable language.

The description must contain a statement of the plan vesting rules, the circumstances which may result in a loss of benefits, and the procedures to be followed in presenting claims for benefits.

In addition, each plan must furnish to each worker a summary of the annual financial report it files with the Secretary of Labor. This report would include a statement of the plan assets and liabilities as compared with the previous year and the receipts and disbursements during the year.

FUTURE DIRECTIONS

The overall effect of this pension legislation will be to affirm the important role of private pensions in providing retirement income for Older Americans. Congress has in this legislation implemented the mandate of the 1971 White House Conference on Aging which directed the Federal Government to take action to insure the preservation of pension benefits by workers and their survivors.

The tax incentives of ERISA respond to the Conference recommendations that broader coverage of the private pension system be encouraged. But Congress was aware that national attention must be focused on the future directions of private pension and welfare plan development.

ERISA created a special joint pension study group to study the impact and implement the future development of this regulatory framework. Specifically, it is directed to study the impact of the new requirements on the hiring of older workers. In addition, this special study group will explore the adequacy of public plans in meeting the income needs of retirement. Reports are to be made to Congress within 24 months of enactment.

Appendix 2

HIGHLIGHTS OF THE STUDY[1] "THE MYTH AND REALITY OF AGING IN AMERICA"—CONDUCTED BY LOUIS HARRIS AND ASSOCIATES FOR THE NATIONAL COUNCIL ON THE AGING, INC.

Because of the sheer mass of data included in this study we are making the following highlights available in advance to interested people in the media. A copy of the complete study, which runs to 245 pages, is available on request.

A press conference to discuss the study was held by Lou Harris and officials of the National Council on the Aging on Tuesday, April 15, at the Mayflower Hotel in Washington, D.C.

This study is by far the most extensive ever conducted to determine the public's attitude toward aging and their perceptions of what it's like to be old in this country—and to document older Americans' views and attitudes about themselves, and their personal experiences of old age.

The National Council on the Aging commissioned the study to provide definitive data to researchers, writers, students, legislators and the general public. For too long the people of this country have accepted without question all of the stereotypes and cliches about growing old. We hope the material that follows will separate the myth from the reality.

The study will also provide base data about the attitudes and perceptions of age for NCOA's newest project, the National Media Resource Center on the Aging; and it will be used with other data to evaluate the results of future programs.

Several points should be made about this data:

First, the findings in the area of public policy are extremely significant. An overwhelming 97 percent of the American people believe that social security payments to the elderly should automatically increase with rises in the cost of living. There is no indication that the public supports an arbitrary limitation on this increase.

The study also reveals that 81 percent of the public agree that the Federal Government has the responsibility to use general tax revenues to help support older people. And 86 percent of the people are opposed to mandatory retirement at a fixed age if the worker wants to continue working and is able to do a good job.

The study explored the attitudes of Americans on a wide range of issues related to aging, and compared the feelings of older people with the perceptions of those younger.

Second, the conclusion is obvious that most of the older people of this country have the desire and the potential to be productive, contributing members of our society. They do not want to be "put on the shelf" and excluded from social and economic activities.

Third, it is clear that most older people feel that their condition in life is better, economically and socially, than the general public believes it to be. But "most" can be a deceptive term; it is vitally important to remember that many millions of older people are living at, or below, the poverty line. Thus, when 15 percent of people over 65 say that "not having enough money to live on" is a personal problem for them, that percentage translates to some 3 million needy people. The same thing is true of many of the other categories discussed in the pages that follow.

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[1] The full text of the report is available from the National Council on the Aging, 1828 L Street, N.W., Washington, D.C. 20036. Members: $15. Nonmembers: $20.

Some of the other major findings include:

PUBLIC POLICY

A full 87 percent of those responsible for hiring and firing say "Most employers discriminate against older people and make it difficult for them to find jobs," and only 37 percent of these decisionmakers feel a fixed retirement age for everyone makes sense.

Among the older public now retired, 37 percent or 4.4 million people said they did not retire out of choice and approximately the same number—31 percent—said they would like to be working now.

Not only should the Government provide income for older, retired people, the public feels it should provide them with enough income to live comfortably. By 76 to 19 percent the public agreed that "No matter how much a person earned during his working years, he should be able to have enough money to live on comfortably when older and retired."

There is tremendous potential support for a movement to improve the conditions and social status of people over 65. Those under 65 (81 percent, compared to 70 percent of those 65 and over) are most conscious of this need for focus and organization.

STEREOTYPES AND PROBLEMS OF OLDER PEOPLE

It is not the young alone who have negative expectations of old age. Recognizing that life is not so terrible for themselves, older people have bought the stereotypes and myths of old age and consider themselves the exception to the rule. In fact, for every older person who feels that his or her own life is worse now than what he/she thought it would be, there are three who say that life is better now than they expected. As many people under 65 feel that their current lives fall short of earlier expectations as those 65 and over. "While I personally am bright and alert," most people 65 and over seem to be saying, "most of my peers simply are not."

A comparison between the problems attributed to "most people over 65" by the public at large and the problems actually experienced personally by older people indicates the extent to which the public has a distorted view of what it is like to grow old. In most cases, the discrepancy is enormous:

> 50 percent of the public felt that "fear of crime" was a very serious problem for the aging, versus 23 percent of older people who thought it a problem for them personally;
>
> 51 percent of the public thought "poor health" a problem for the aging, versus 21 percent of older people who thought it a person problem;
>
> 62 percent of the public thought "not having enough money to live on" a problem for the aging, versus 15 percent of the elderly who found this a personal problem.

It is striking that in the above examples, people over 65 substantially agreed with those younger that these were problems for "most people over 65." But by the percentages indicated, individual older persons considered themselves exceptions.

Except for health and fear of crime, the "very serious" problems of those 18–64 are very comparable to those who are 65 and older, including not having enough money, job opportunities, medical care and education.

OLDER PEOPLE, THEIR LIFESTYLE AND PERCEPTIONS

It is generally recognized by the public at large that people over 65 represent a larger segment of the population today than 10 or 20 years ago. And, as a group, people over 65 are seen as healthier, better educated, and in better financial shape than in the 1950's or 60's.

But when queried as to the type of life older people lead, the perception, again, is quite different from the reality.

In the eyes of the public, people over 65 spend a great deal of their time in sedentary, private and isolated activities. Actually the older public is far more active than imagined.

> Sixty-seven percent of the total public expects that most people over 65 spend a lot of time watching television. Only 36 percent of the older group report they do.

Sixty-two percent of the public at large expects that older people spend a lot of time "sitting and thinking". Only 31 percent report they do.

In fact, pastime activities of both young and old are very similar. Comparable numbers of the old and young, for example, spend a lot of time sleeping, reading, sitting and thinking, participating in fraternal or community organizations or going for walks. The only areas where the two groups part are: older people spend more time watching television than the young, while the younger group spends more time in child care, at a job, or engaged in sports.

Additionally, the physical and sexual activity of the over 65 group is misperceived by the general public.

The total public expected that less than half (41 percent) of the older group was "very physically active," while 48 percent of those over 65 report they are. And, only 5 percent of the total public expected older people to be "very sexually active", compared to the 16 percent of the older men and 7 percent of older women who say they are.

While the young picture older people as engaged in passive sedentary activities and not an active part of society, older people are unwilling to be relegated to the sidelines. They do not wish to be excluded from things happening around them, nor limited to communities for older people. Like the young, three out of four people 65 and over said they prefer to spend most of their time with people of all different ages.

BECOMING OLD AND SELF IMAGE OF OLDER PEOPLE

When does one turn the corner and become old? Public opinion varies. Only half the public (53 percent) picked some specific age as the criterion for "old age"; the other half has a less chronological, numerical concept, citing "retirement", "health" and "it depends" as the criteria.

Of those who do state a fixed age, the largest block (23 percent) feels the average man or woman becomes old in the 60's. And while some may argue that women age faster than men, or vice versa, most people do not feel this way.

Seventeen percent of the public think that women become old before they're 60, compared with 16 percent who feel that way about men.

Age does not appear to influence significantly the way individuals tend to view themselves. The public 65 and over sees itself as being as bright, alert, open-minded, adaptable, and as good at getting things done as those 18–64.

Those 65 and over have a higher self-image in terms of being "very useful members of their community" (40 percent) than the younger group (20 percent). Yet the younger public's view of their elders is even lower than their own self-evaluation. Only 21 percent of the younger group consider most people over 65 to be "very useful."

Older whites tend to have a more positive image of themselves than do older blacks. In only a few areas do the two groups come close together in their self-image—in seeing themselves as friendly and warm, wise from experience and sexually active. Some of the same differences exist between younger blacks and whites, but to a lesser extent.

PREPARATION FOR OLD AGE

Majorities of the total public agreed on seven "very important" steps people should take in preparing for later years: provision for medical care, making of a will, savings, learning about pensions and social security, buying a home, development of hobbies, and deciding whether to move or stay put.

Blacks in general are less well prepared for old age than older whites. Less than half as many blacks as white have built up savings, 25 percent more older whites than blacks own their own homes. But higher numbers of blacks than whites have talked to older people about what it's like to grow old and have moved in with their children or other relatives.

ADDITIONAL FINDINGS

Like percentages of the young and old feel that parents and grandparents over 65 assist their off-spring in various ways. The young credit parents and grandparents with less assistance than the older generation claims in helping out when someone is ill, taking care of grandchildren, and help out with money. Also, the young say the old give far more advice than the older generation admits.

It is not necessarily surprising that a substantial proportion of those 65 and over (45 percent) feel they get less respect from the young than they deserve. What might be surprising is that a full 71 percent of the public 18 to 64 feel that people over 65 get "too little respect" from young people these days.

Blacks 65 and over feel more than older white (60 percent vs. 43 percent) that they do not receive enough respect from the young.

Managers, officials and proprietors make up 18 percent of the people past 65 who are still working; salespersons, 10 percent, and service workers, 17 percent. A full 22 percent of retired people were skilled craftsmen or foremen, while only 11 percent of those still employed hold those jobs.

The current volunteer force among older people is 4.5 million strong. Another 10 percent of the 65 and over public said they would like to volunteer their services. Thus the potential total number of a volunteer force among older Americans is 6.6 million.

But people 65 and older are not interested in doing volunteer work exclusively. Old and young alike, while willing to accept their share of uncompensated community service, also feel that if a person's work is valuable, he or she should be paid for it.

Few people in this country single out the later years as the most desirable period of one's life. Substantial numbers (69 percent) consider the teens, 20's and 30's as "the best years of a person's life". Those who did identify the later years as the prime of life associated that period with the advantages of youth—a time of few responsibilities, problems and pressure, a time to withdraw from productive roles, to take it easy and enjoy life.

Not only do four in five older people look back on their past with satisfaction, three in four feel that their present is as interesting as it ever was, and over half are making plans for their future. While life could be happier for 45 percent of older people, an even higher 49 percent of those under 65 feel the same. Income, education and employment status appear to have far greater affects on overall life satisfaction than age or race.

The study might be characterized by this observation from the section *The experience of being older:*

"There appears to be no such thing as the typical experience of old age, nor the typical older person. At no point in one's life does a person stop being himself and suddenly turn into an "old person," with all the myths and stereotypes that that term involves. Instead, the social, economic and psychological factors that affect individuals when they were younger, often stay with them throughout their lives. Older people share with each other their chronological age, but factors more powerful than age alone determine the conditions of their later years."

Appendix 3

NEW FEDERALISM AND AGING[1]

(By C. L. Estes, Ph. D.,[2] Human Development Program, University of California, San Francisco, Calif.)

New Federalism is a term used to describe the revised concept of the role of the Federal Government in directing more accountability to elected officials in States and localities. The idea is that those closer to the people are better able to solve their own problems. New Federalism programs theoretically provide for State and local determination of problems and solutions—and as such they are expected to transfer power from Federal bureaucrats (and, to some extent, from national legislators as well) to elected and appointed leaders and their staffs in the States and localities.

The major arguments given for the initiation of New Federalism proposals in the form of revenue sharing have been that: (1) There is a growing fiscal crisis of State and local governments attributed to their lack of ability to constantly increase taxes (e.g., property or sales taxes) or to raise other revenues in proportion to their increased expenditures; the hope was that the redistribution of Federal revenues through revenue sharing would result in an overall increase in funding available for State and local programs; (2) there has been increasing administrative and programmatic fragmentation at the national level which has made Government programs less and less responsive to the needs of the population; (3) States and localities could determine a more effective allocation of resources from revenues if they were given the authority to do so; and (4) there has been an increasing (and disproportionate) concentration of power in Washington which has been not only expensive but also insensitive to program needs at local and State levels (Beyer, 1974). The fifth and sixth arguments which have been less publicized are (5) that revenue sharing was the Nixon administration's major hope of slowing down the growth of categorical programs (Muskie, 1973); and (6) that this same administration embraced revenue sharing as a mechanism for redistributing political power (Brookings Institution, 1973) from national policymakers to local ones, and to no small extent, to the White House as well (Muskie, 1973; Brookings Institution, 1973; Banfield, 1971).

Although each of these arguments has been (and continues to be) challenged, legislation enacting the first major New Federalism program, known as "General Revenue Sharing," was passed and signed into law on October 20, 1972—providing a 4-year test of the underlying soundness of some of the above arguments.

In assessing the impact of this and other New Federalism legislation, an important concept to consider is that revenue sharing may be conditioned or unconditioned.

Conditioned revenue sharing restricts the use of revenue sharing funds to fulfilling some specified federal intent—requiring, for example, that States and localities be concerned with specific programs or goals that Congress and/or the executive branch deem to be in the national interest. The major benefit of conditioned grants is that, in being restricted in some manner, it is possible, for example, to assure that expenditures are allocated in specific programs designed to help people (e.g., through cash, services, or environmental manipulation). Special Revenue Sharing is a term used to refer to conditional revenue sharing.

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[1] See p. 96 of this report for additional discussion of revenue-sharing.

[2] After July 1, 1975, Assistant Professor, Department of Social and Behavioral Sciences, University of California, San Francisco.

Unconditioned grants permit the unrestricted or discretionary use of funds. As such, the primary beneficiaries are likely to be the governments themselves because such funds may be utilized to assist governments which do not have adequate fiscal capacity in the areas they choose, or require.

General Revenue Sharing (through the State and Local Fiscal Assistance Act of 1972) represents the current major effort to operationalize the New Federalism principle in terms of relatively unrestricted funding. This act provides State and local authorities the power to use Federal tax funds in ways they themselves devise; it is essentially unconditioned. As provided in P.L. 92-512, more than $30 billion of general revenue sharing (GRS) money is allocated for expenditure between January 1, 1972 and December 31, 1976, when the act expires.

Under this legislation, one-third of the GRS funds available are distributed to the States while two-thirds are distributed to local governments (cities and counties). The formulas employed in computing the amounts of funds which will be distributed are both complex and controversial. Included in these formulae however are computations based on (1) population, (2) urbanized population, (3) per capita income, (4) State income tax collections, and (5) tax effort (the five-factor House formula) and computations based on (1) population, (2) tax effort and (3) income (the three-factor Senate formula). The higher of these two amounts is selected for each State (U.S. Joint Committee on Internal Revenue Taxation, 1973). Of each State GRS amount, one-third is allocated to State government and two-thirds to local governments, according to each State's formula, which must meet certain Federal requirements. The allotment of GRS funds provided under this 1972 enactment is restricted only to the extent that their use be for (1) "ordinary and necessary capital expenditures" and/or (2) "ordinary and necessary maintenance and operating expenses" in any of eight priority areas (public safety, environmental protection, public transportation, health, recreation, libraries, social services for the poor or aged, or financial administration).

It is important to note that there is no requirement that these general revenue sharing monies address any one of the maintenance and operating expenses in any of the above eight categories. That is, all $30 billion of available general revenue sharing monies may be spent in toto for capital expenditures (e.g., construction costs), resulting in the very real possibility that there will be no allocated GRS expenditures for social services for the poor and/or aged. In other words, GRS is so broad it is "unconditioned" in the sense described previously. As such, it provides much flexibility to State and local officials in their use of these funds. Unfortunately, however, the fact that this money is not believed to be permanent affects their decisions regarding use of these funds. Although GRS was "billed" by its legislative supporters as "new money," it is widely feared not only that the sums available are likely to vary widely over time, but also that they are not new money at all. To the contrary, it is believed by many State and local officials that this money must replace other sources of Federal revenue—that even with general revenue sharing funds an overall decrease in funding assistance to States and localities from the Federal level may well result.

Many issues exist regarding the validity of this claim. Factually, it appears that some States and localities have actually fared worse while others have come out better in terms of the total available funds from general revenue sharing and other sources. These discrepancies are partially due to the aforementioned formulas for computing revenue sharing allocations.[1] These discrepancies, and attendant fears about the instability and overall benefits of GRS also derive in part from the Nixon administration's large budget cuts immediately following the enactment of Public Law 92-512 and from enacted and proposed special revenue sharing programs which have or can result in other types of reductions and/or redistributions in the flow of Federal funding to States and localities.

The second major concept of New Federalism, thus, becomes important to consider. This is the conditioned or special revenue sharing. It represents a form of revenue sharing which is more restricted in the sense described previously. As envisioned, debated, and partially enacted, it would merge a plethora of some 130 categorical programs into functionally related areas. If enacted across a number of areas as initially envisioned, special revenue sharing monies would be used only for delimited purposes and would replace existing grant-in-aid categorical programs with block grants. As conceived, this type of revenue sharing would

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[1] For example, at one time Mayor Alioto estimated San Francisco would lose $76 million in federal funds which had previously been available for urban renewal, housing, and so forth, as a direct result of cutbacks in categorical programs due to revenue sharing.

> . . . allow almost unlimited State flexibility in the choice of social service interventions, while . . . confining the Federal role to specifying and measuring national objectives for the [specific] social services (Mogulof, 1973).

Theoretically special revenue sharing is a way of providing for goal determination at the Federal level, while the determination of means are assigned to the local level.

The areas first considered for such legislation were urban development, rural development, transportation, education, law enforcement, and manpower training. Some of these (e.g., Comprehensive Employment and Training Act (CETA) and the Housing and Community Development Act) have already been passed. Others (e.g., special revenue sharing in health) continue to have difficult sledding or to be only partially enacted.[2]

Of significance in any attempt to assess the impact of New Federalism for aging programs is the fact that currently there is no proposed or anticipated legislation which may be called special revenue sharing for older persons. Further, the effects of the elimination of categorical grants specifically for aging programs under such an approach must be seriously considered as well as the impact of this strategy for the plight of the aged. Also, it is significant that many of the special revenue sharing packages which have been and are being passed and implemented mention or allow for special provisions for older persons, but they do not require specified "shares" of these funds for the aging population.

Even more important, there is not now—nor is there proposed—the establishment of a Federal-level office or agency to coordinate information or to examine the potential impact of the various separate "special" revenue sharing acts either on any target populations or on the total distribution of funds. As a consequence, it would appear that the block-grant (special revenue sharing) approach to programs and services will be no less fragmented nor more carefully planned or responsive than are the existing programs which these special revenue sharing enactments seek to consolidate.

As the previous discussion hints, there are numerous major problems and issues which relate to the New Federalism principle in general and specifically to allocations under general revenue sharing, as well as to enacted and proposed special revenue sharing legislation.

The major issues involve:

(1) Lack of credibility regarding the permanence and fear of hidden penalties in general revenue sharing (GRS), better described as State and local officials' wariness regarding the permanence of such funds and the extent to which their allocation will be accompanied by cutbacks in categorical programs. This general area of concern has resulted in the unwillingness of State and local officials to use general revenue sharing (GRS) monies for "new starts." Characterization of GRS as "one-time-only" monies has been employed to explain the high percentage of capital expenditures and the high percentage of support for ongoing programs and services with GRS funds rather than for the support of noncapital expenditures or the creation of innovative new programs.

A critical problem is that in order to be responsive and to plan, States and localities must know with certainty: (a) What funds they will have, (b) the exact time-period for which these funds will exist, and (c) under what conditions, and with what constraints, such funds will be available. Unless such funding is legislatively mandated and assured at the national level, the current lack of credibility and uncertainty regarding the permanence and funding support for revenue sharing programs will persist—prohibiting a true test of what States and localities would do with such funds without being motivated by these concerns.[3]

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[2] A Health Revenue Sharing and Health Services Act (H.R. 14214) was pocket vetoed by the President in December 1974. Yet the National Health Planning and Resources Development Act (P.L. 93-641), signed into law by the President January 4, 1975, requires the states to designate a series of Health Systems Agencies (HSA's) which, like AAA's, are to (a) develop health service plans, (b) review institutional health services, and (c) make grants to develop health programs and projects. As such the HSA's are the New Federalism embodiment for health, which the AAA's represent for aging.

[3] In a recent survey of 45 jurisdictions, only one-third of the 12 States studied treated GRS as new money. See U.S. Senate Committee Governmental Operations, Subcommittee on Intergovernmental Relations." How 45 Selected Jurisdictions View Revenue Sharing," committee print, June 1974.

(2) Lack of trained personnel at state and local levels to assure that such funds are actually used to provide more responsive, planful expenditures and programs at these levels.[4] At the current time, no one knows really what capacities exist at state and local levels of government for such responsbilities (Banfield, 1971).

(3) The redistribution of power and potential increase in politically motivated (rather than need-based) determination of programs and allocations for services. Given almost complete discretion in determining use of funds in the case of GRS, state and local decisionmaking regarding its use is likely to become more intensely political. The accessibility of local politicians to local interest groups will heighten pressures on them, possibly encouraging corruption at State and local levels. The relative uniformity and restrictive input provided by Federal programs are lacking in GRS funding, resulting in less necessity for State and local politicians to make compromises toward any broad national objectives, in spite of the priority categories. (Interestingly, however, some political observers argue that there would be less politics, fewer compromises and fewer tradeoffs with GRS because of the local officials' strengthening of their political positions due to their discretionary authority over the spending of Federal funds [Banfield, 1971].)

(4) The criteria (formulae) for the allocation of revenue sharing dollars to States and localities. It has been argued that the current formulae for GRS reportedly benefit the wealthy States which do not have large numbers of poor or elderly residents. Many States and localities have reported that they have actually lost large sums of previously available program dollars because of (1) the formulae for disbursing GRS money and/or (2) cutbacks in categorical programs.[5]

(5) The criteria for judging the success of this transfer of accountability. How can the responsiveness in revenue sharing programs be evaluated, and how much accountability should be required? Proponents of these programs assert that the electorate will vote out state and local officials who are not responsive to their needs—presumably more closely aligning programs with the needs of the people. It is argued that the Washington bureaucrats (controlling national programs) have been free to be unresponsive because there is no electoral process by which to recall them. The unwarranted assumption, of course, is that politicians who are unresponsive will be recalled. This presumes the electoral awareness of the responsiveness (or lack of it) of State and local officials in the distribution of revenue sharing monies, through a most complicated maze of alternatives about which there remains little public understanding or involvement).[6]

(6) the extent to which GRS and other New Federalism programs represent the closing out of categorical programs at the Federal level, and the impact of such closures not only on the States and localities, but more importantly, on the human beings who receive services from categorical programs in those states and localities. Given the lack of coherence to the many individual legislative packages which comprise elements of special revenue sharing, it is difficult (if not impossible) to assess the significance of this issue. Nevertheless, this is probably the most significant and potentially threatening issue around which any serious consideration of general and special revenue sharing must pivot.

Both general and special revenue sharing and the basic ideas which lie behind them have particular relevance for aging programs at the local, State and national levels. Here the central issue concerns what the new Federalism and, in particular, general revenue sharing mean for aging programs.

This issue and whether or not such New Federalism programs are generally beneficial for aging programs requires consideration of the following types of questions:

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[4] Elazar argues against this position. See Daniel J. Elazar, "Are the States and Localities Responsible," testimony hearings before the U.S. Senate Subcommittee on Intergovernmental Operations, Committee on Government Operations, June 1, 3, 8 and August 3, 1971, pp. 322–330.

[5] RANN-National Science Foundation has funded research to examine implications of different formulae for such determinations.

[6] The lack of citizen involvement in the actual decisionmaking regarding revenue sharing allocations in the States and localities has been widely publicized. Unfortunately, neither Federal regulations nor the existing revenue sharing laws require formal citizen input, public hearings, and so forth. The result has been not only a retreat from human services but also the avoidance of civil rights compliance in some of the GRS funding. This too, has been nationally publicized. See U.S. Senate Committee on Government Operations, Subcommittee on Intergovernmental Relations, committee print, June, 1974, p. 2; and Muskie (1973:588 ff).

Does the New Federalism strategy (or will it) result in reduced funding for services in aging? With general revenue sharing? With special revenue sharing?

Does it (or will it) mean noncategorical funding and/or the total elimination of categorical programs in aging? Including even those funded under the Older Americans Act?

Regardless of the answers to the above questions, if New Federalism is here to stay, advocates and gerontologists must also consider and suggest the optimal ways of benefiting the elderly under such a strategy. Part of the answer to this question lies in the relative success of the area agencies on aging (AAA's) as illustrative of the New Federalism principle of increased local control and the actual results of area planning in augmenting services for older persons. Essential questions, then, include those of whether or not AAA's have been able to increase the overall service dollars in their communities for aging programs, and the extent to which revenue sharing monies have been successfully acquired by the AAA's for aging programs.

What do current data indicate in this regard? Before summarizing the available information on this subject, it is important to emphasize that the types of data which are available are extremely inadequate for our purposes. Most notably there are no data on the types of services or on the types of beneficiaries if any of such services supported by GRS funds under any category (e.g., health). Therefore it is not possible to ascertain the extent to which older persons are among service recipients for any general category of service. Even more significantly, as the data are currently collected, it is not possible to differentiate between services spent for the poor from those spent for the aged, because of the combined category used.

While the general revenue sharing law is only 3 years old, available data regarding its use indicate that most of the GRS funds are being spent by the States and localities to support construction or other nonrecurring "capital expenses" or to provide tax relief rather than to support "maintenance and operations" of ongoing services (with the exception of those in public safety and education). As noted previously, this may be due to the uncertainty of how long revenue sharing will last (the current authorization expires at the end of 1976) and to the interest of local politicians in spending for "visible" items that will demonstrate to their constituents their contributions to the "public good."

Consequently, social services have consistently been low priority under GRS funding. For example, a report compiled by the Treasury Department in June, 1973 indicated that only 8% of the GRS monies were going for social services, revealing that:

> State and local governments are pouring general revenue sharing money into building projects and "public safety" while virtually ignoring social service programs. . . . According to the survey, which covered the reported use of $5.1 billion of general revenue sharing funds by 574 units of State and local government, only 8 percent of the total was invested or planned for use in social service areas. State governments reported no money invested in either community or economic development. By contrast, 72 percent of all governmental units said their top priority for use of the money was capital investment (building projects), and 57 percent put public safety expenditures in the list of the top three priorities.

More recent data reported in January 1975 (U.S. Office of Revenue Sharing, 1975) indicate that 36 percent of all GRS funds have been expended for capital outlays, while 64 percent have supported the maintenance or operation of programs (only a quarter of which were new). Of the $9.5 billion expended as of June 30, 1974, only 4 percent had been allocated to services for the poor or aged. Interestingly, States had made a larger commitment than local governments in this area, expending 7 percent and 2 percent respectively for services for the poor or aged.

More detailed (and disheartening) information of relevance to older persons is provided in a communication from the U.S. Comptroller General's Office to an inquiry on the topic from U.S. Representative Claude Pepper in early 1974. This letter contained the results of a study of a sample of governments, "selected primarily on the basis of dollar significance and geographical dispersion," which had authorized GRS expenditures prior to July 1, 1973. Study findings indicate that:

> Of . . . 218 governments, 28 authorized the expenditure of part of their Revenue Sharing funds in programs or activities specifically and exclusively for the benefit of the elderly. . . . About two-tenths of one percent [our underline] of the total funds [were] authorized for expenditure by the 218 governments [for aging].[7]

This is the more realistic and dangerous result of backing off from national objectives with unconditioned revenue sharing. For whatever reasons, when released from Federal requirements, programs for the elderly are likely to slip into oblivion across this Nation under such a strategy. This is extremely probable because unconditioned revenue sharing essentially means that the support for aging programs would have to be renegotiated with advocacy efforts in each of the more than 39,000 individual jurisdictions which receive revenue sharing funds. As just shown, the disposition is for State and local governments to spend money on capital outlays, tax abatement, public safety, and more recently on education. Given this trend and the known problems of State units on aging (SUA's) in successfully negotiating with other State agencies for additional resources for the aging, it is not likely that general revenue sharing funds will be effectively mobilized on behalf of the aging, or even for social services in general.[8] In addition, while the relative success of area agencies on aging (AAA's) in obtaining GRS funds is not known (an interesting fact in itself), from the one preliminary State study of such efforts which this author has reviewed, the prognostication for AAA's for securing GRS monies is not much brighter than that for the SUA's. California counties recorded an average allocation of .0704 percent of its GRS funds for social services for the aged and poor (California Office of Economic Opportunity, 1974).

As early as 1972 the problems and prospects of New Federalism strategies for aging programs were discussed by Robert Hudson and Martha Veley. Predictably, perhaps, their discussion was no more optimistic than that presented in this paper. To quote these authors:

> A growing suspicion in Washington of service programs in general, the Federal role in them in particular, and various forms of revenue sharing may all have major impacts on the State units on aging (SUA's).
>
> Revenue sharing as an option raises a number of very basic issues for the SUA's. At this point in time, it is unclear exactly how much revenue sharing money will be made available and what forms it will take.
>
> Insofar as general revenue sharing is concerned, [there is] little indication that the SUA's have had access to these funds. . . .
>
> The data . . . suggest that the SUA's have not made significant inroads into the priorities and programs of other State agencies. . . . If we can assume that competition for Federal dollars will involve mainly the State agencies dealing in the social services with some additional inputs from the Governor's offices, the relative success the SUA's have enjoyed in State legislative endeavors is not as promising as it may appear under current conditions. Were the existing categorical grant protection afforded the SUA's to be substantially scaled down, strength in dealing at the "State bargaining table"—albeit for Federal dollars—would be essential. To this point, the SUA's have not demonstrated such strength.
>
> In sum, our point is that events may conspire in such a way as to make life very difficult for the SUA's. While the capability to undertake what we have termed leadership-planning[9] activities will be critical should social services special revenue sharing be enacted,[10] the SUA's are currently pre-

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[7] Excerpted from page 2 of an undated letter to the Honorable Claude Pepper, U.S. House of Representatives, from the Deputy Comptroller General of the United States, in response to Representative Pepper's November 14, 1973 inquiry on the extent to which GRS funds were being allocated to programs specifically and exclusively designed to benefit the elderly.

[8] The January, 1975 summary from the Office of Revenue Sharing indicates that through June, 1974, the category of health received 7 percent of GRS monies; recreation, 4 percent; transportation, 15 percent; and education, 22 percent. It is not known to what extent these funds were for capital outlays for new services in any of these categories.

[9] "Leadership-planning" refers to the activities resulting in the mobilization of resources through planning and coordination. See The Roles and Functions of State Planning, Preliminary Report on a Nationwide Survey of State Units on Aging, 1972," Robert H. Binstock, Principal Investigator, Waltham, Mass.: Brandeis University, 1972.

[10] Title XX of the 1974 social services amendments to the Social Security Act represents one version of special revenue sharing for social services. The aging receive no special attention in these amendments, simply being listed among a number of other categories of potential beneficiaries.

> occupied with overseeing the development of planning and service structures (the area agencies on aging) which deal on the sub-State level (Hudson and Veley, 1972:14–15).

An important point which Hudson and Veley make is that the 1973 amendments to the Older Americans Act are drawing SUA resources toward the establishment, assistance and support of area agencies—thereby diminishing available SUA resources and energies for the intense State level advocacy required to secure GRS monies and special revenue sharing dollars for social services for the aged. The overview of data just reviewed—drawn jointly from revenue sharing reports and from the Brandeis study of State units on aging—do not provide a very hopeful prognosis for the ability of State and area agencies on aging to obtain a just share of New Federalism monies for the elderly of our nation.

As Kaplan (1973) indicated:

> While it is true revenue sharing puts money where the need is, it does not mean the money will be used for needs not fully recognized; while it moves money and power closer to the people, it does not mean those in power will release money to the people, even when the latter so request; and, while it relies on local accountability, it does not mean the elderly are regarded as being a group to which one must be as accountable compared to another group (editorial page).

Although the Federal regulations for title III of the 1973 amendments to the Older Americans Act speak specifically of tapping general and special revenue sharing funds on behalf of the aging, no requisites for doing so are set forth, and these regulations represent little more than a legitimization of efforts to secure such funds in the States and localities where aging interests are admittedly weak or diffuse. Further, should special revenue sharing supplant the existing categorical grant-in-aid programs (of which the Older Americans Act is considered by the current administration to be one), the dangers for State units on aging (SUA's) and area agencies on aging (AAA's) would be extremely grave. Current nationwide evidence provides no reason to think that the large majority of SUA's or of AAA's would fare well if Federal monies for social programs were entirely allocated at the State and local levels among competing interests (i.e., without the fixed Federal funding of categorical aging programs at those levels).

Lacking a core of professionals and key governmental figures backed by a mobilizable force of older persons, it will be difficult for persons who are in the aging field to bring revenue sharing funds of any kind to bear on the problems of the aging even with the current categorical Older Americans Act programs.

MAJOR AGING RELATED ISSUES

There appear to be four key issues related to the New Federalism and programs for the aging. These are:

1. Should aging policy be national? Should parts of it? Is it important to distinguish those state and local needs that are in some sense national and those that are not? Are there overriding areas and directions which must not be left to the local bargaining systems—or perhaps to chance, if you will? And, to what extent does New Federalism represent a drawing away from categorical programs in aging?

2. What is likely to be the impact of the New Federalism decentralization on States? On localities? As far as aging programs are concerned, given the limited resources now available, the 1973 amendments to the Older Americans Act represent a drawing away from the efforts of State units on aging in terms of State level advocacy, State level coordination and planning—in favor of technical assistance to and the operational development and monitoring of AAA's. The direction of advocacy is back to the local areas—reemphasizing the importance of the AAA's and other local organizations of and for the aging in advocacy efforts to strengthen access to local power and resources. The problems and issues then becomes one of capability, commitment and power at the local level.

3. And what is the role of organizations working for advocacy at the national level in the field of aging? The New Federalism means the politics of decision making on allocations for aging programs will be dispersed to some 39,000 disparate jurisdictions (States and localities). As such it diminishes the influence not only of the U.S. Congress but also of national organizations and interest

groups in aging which have served as the major mechanisms for securing power and resources for the elderly.

4. It is reasonable to assume that State and local governments will engage in social planning and resource allocation procedures in preparation for the development and implementation of block grant funded programs, as proponents of the New Federalism essentially argue? This question raises obvious issues regarding the staffing, capability, and commitment of States and localities to long term and coherent strategies, priorities and objectives. It also requires serious consideration of the enactment and implementation of federal mandates for minimum standards in some of these areas.

Given the previous discussion and analysis presented in this paper, what is the current challenge for State and area agencies on aging, for national legislators and advocates of aging programs, for us as gerontologists?

There appear to be at least four options. These are:

1. *Build up the Federal programs.*—Work against the New Federalism strategies; strengthen national policies in aging.

2. *Go to work at the State and local levels.*—Accepting that New Federalism is here to stay. Recognize that programs for aging are increasingly going to depend on the ability to generate power at the local level. Involve and organize older people through AAA's, and local governments, through private agencies; advocate with State legislatures and local government officials for specified funding levels under both general and special revenue sharing legislation.

3. *Some combination of 1 and 2.*—Work at the State and local levels and advocate for Federal legislation. Get aging into special revenue sharing proposals, with a heavy emphasis, or establish special revenue sharing solely for persons 60 years of age and older, and propose legislation at both the State and local levels to allocate large proportions of the existing general revenue sharing monies allocated or designated for aging programs in proportionate amounts at least equivalent to the proportion of persons 60 years of age and older in the population at each of these levels.

4. Do nothing; accept whatever happens. Let the chips fall where they may.

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Appendix 4

REPORTS FROM FEDERAL DEPARTMENTS AND AGENCIES

ITEM 1. DEPARTMENT OF AGRICULTURE

FEBRUARY 11, 1975.

DEAR MR. CHAIRMAN: Enclosed in response to your letter of December 20, 1974, to Secretary Earl L. Butz, is a summary of major activities on aging by the Department during 1974. Included in the summary are statements regarding the continuation of activities in 1975.

If we can assist you further, please let us know.

Sincerely,

JOSEPH R. WRIGHT, Jr.,
Assistant Secretary for Administration.

[Enclosure]

ACTIVITIES OF THE U.S. DEPARTMENT OF AGRICULTURE TO HELP OLDER AMERICANS

ECONOMIC RESEARCH SERVICE

The Economic Research Service carries on several studies designed to gain insights into the problems faced by elderly people living in non-metropolitan areas. Over 36 percent of our Nation's 20 million older citizens live outside standard metropolitan statistical areas. In addition, many mid-American farm belt states have a relatively high concentration of people 65+ years old. The following studies have been continued during calendar year 1974.

SOCIAL ASPECTS OF AGING IN APPALACHIA

Existing information suggests that the well-being of the aged, compared to younger persons, tends to be higher in rural than in urban counties. This research examined the hypothesis that deterioration in attitudes with advancing age is greater in a metropolitan center than in a more traditional rural community. Data were collected by personal interview with 803 persons who comprised representative samples of men and women aged 20–29, 30–44, 45–59, and 60 and over in a rural county in the Southern Appalachian Region and in a metropolitan center outside the region.

Each person gave an "agree-disagree-don't know" response to 72 statements constituting 24 attitude scales about self-image, morale, general outlook, family life, economic conditions, and community life. Mean attitude scale scores were compared for the two communities controlling for age, sex, and education. Attitudes deteriorated slightly with old age in both communities, but the most discriminating variable was level of formal education rather than a modern versus a traditional type of community. Sex differences in attitudes were greater in the urban than in the rural community. It appears that the commitment of the rural people to a modern way of life is strong enough to eliminate important differences in the subjective life of the two communities. The findings serve to question the validity of attributing the problems and difficulties of older people in contemporary urban society to the technological and social changes accompanying urbanization and industrialization. Further, the modest differences in subjective life by virtue of age group suggest the desirability of developing programs based on needs rather than age groupings.

COMPARISON OF SYSTEMS FOR CARE OF AGED IN RURAL AREAS

The first part of this study represents a pilot effort to determine attitudes that 200 Arkansans in the 55- to 65-year-old age bracket had toward nursing homes. The inferences that result from this report reflect the views of the sample population only and do not necessarily represent feelings elsewhere in the State or nationwide.

The main conclusion that came out of this study was that the sample population wanted to be independent and maintain their own homes for as long as possible. It was noted that respondents would stay in their own homes even at some risk to their lives. None of the respondents planned to retire to nursing homes and only a few (27 percent) *preferred* to go to a nursing home in the event of a long-term serious health problem.

The sample population felt that a number of services to be found in nursing homes were important. The most important of these services was having expert medical care readily available, maintaining the body through physical therapy, and maintaining alertness and usefulness through craft activities. Respondents were concerned for the mental and emotional needs as well as the physical needs of the elderly. The respondents were insistent that the need for respect and dignity be recognized by the institution. Most respondents viewed the nursing home as a "good" place for the old, but they found it difficult to look at themselves living in a nursing home. The respondents were very concerned about loss of independence and lack of privacy. If a feeling of privacy and ownership could be established within the nursing home, much of this resistance could be removed.

A major implication from this study is that elderly persons will be likely to remain in their homes just as long as possible in spite of increasing symptoms signaling deteriorating health. Thus, when finally forced to seek health services, their recovery is likely to be prolonged, partial or worse, and extremely expensive because it is labor intensive. This offers a major policy opportunity to formulate outreach programs for the elderly designed to reduce unnecessary suffering and demand for hospital services. Also, such programs could permit maintenance of the sense of well-being of senior citizens as associated with living in their own homes.

Future studies will concentrate on the costs of developing low cost outreach programs as a substitute for hospitalization. Researchers also plan to study nutritional programs for the elderly.

A PILOT SURVEY OF THE RURAL ELDERLY

ERS plans to conduct a pilot survey of elderly persons in a selected rural Kentucky county during 1975. The purpose is to determine if reliable information can be obtained on economic conditions and special problems faced by the target group and to evaluate both present services and potential demand for new services. This data would provide basic demographic and economic information on the elderly including estimates of "in-kind" income and wealth holdings. Researchers will analyze those factors contributing to the demand for services and evaluate the effectiveness of present public programs designed to benefit the elderly. Finally, the survey will provide a testing ground for questionnaire design and for the problems involved in surveying rural elderly people.

IMPROVING HOUSING FOR THE RURAL AGED

The quality of housing occupied by the aged has not improved as rapidly as that occupied by the younger households. For example, 32 percent of the substandard housing in the United States was occupied by households whose heads were over 65 years of age in 1970 as compared with 24 percent in 1960. About half of the poorly housed aged are located in rural areas. Lack of progress in improving housing for the aged may be due to a variety of factors such as location, tenure, household composition, and income distribution. An ERS study is underway to determine what factors are affecting the quality of housing occupied by the aged in rural areas and the types of programs which may be most effective in helping the aged improve their housing conditions.

FARMERS HOME ADMINISTRATION

This rural credit agency of the Department of Agriculture administers 27 loan and grant programs. Eligible persons, regardless of age, participate equally in all. In the loan program for rental housing, borrowers who plan to provide housing for persons 62 years of age or older may receive special terms.

Housing is of special interest for those seeking ownership of individual homes, repair of homes they own, or rental apartments in rural areas. Farm ownership and operating loans are used by the elderly to a limited degree. Water and waste disposal loan programs include older people in the clientele they serve.

Two new programs, loans to establish rural businesses and industries, or those for community facilities in towns of 10,000 or smaller, have lent themselves to amenities that have special interest for the elderly—clinics, hopsitals, doctor's offices, ambulance or emergency service, fire stations and nursing or retirement homes are among the purposes for which loans have been made in these two programs.

FOOD AND NUTRITION SERVICE

FOOD STAMP PROGRAM

This program enables low-income households to buy more food of greater variety to improve their diets. Participants purchase food coupons in amounts based on family size and net monthly income and receive a larger value in food stamps. These food coupons can then be spent like money in participating food stores.

The 1973 amendments to the Food Stamp Act include changes that benefit the elderly and other participants. Food coupon allotments are to be adjusted twice a year instead of once a year to reflect changes in the cost of the Economy Food Plan on which the Food Stamp Program is based. The first such adjustment was made on January 1, 1974, to reflect August 1973 food prices.

Another temporary amendment permits those receiving payments under the Supplemental Security Income Program to continue participating in the Food Stamp Program unless they live in one of the States that is providing the bonus value of food coupons in cash. These States are New York, California, Massachusetts, Wisconsin, and the aged and blind in Nevada.

In the 1973 amendments, the Congress took additional steps:

—Mandated a nationwide Food Stamp Program by June 30, 1974, in all political jurisdictions including Puerto Rico, Guam, and the Virgin Islands unless a State can demonstrate that such a step is impracticable.

—Imported foods and garden seeds and plants to produce food for human consumption may now be purchased with food stamps.

—Food coupons may be used by elderly recipients for meals prepared by senior citizens centers, apartments buildings occupied primarily by the elderly and other facilities that offer meals to the elderly during special hours set aside for them.

To assist in the nutrition education of senior citizens, the Food and Nutrition Service has available a cookbook entitled, "Cooking for Two," which is printed in large, easy-to-read text. The cookbook provides menu ideas, helpful hints on planning and serving meals for one- and two-person households in addition to information on foods needed to maintain health.

FOOD DISTRIBUTION PROGRAM

Phaseout of family food distribution and implementation of the Food Stamp Program in virtually all areas of the country by June 30, 1974, was mandated by Public Law 93-86. Thus, by November 1974, only 111 areas were still distributing foods to needy families. After Island-wide transfer to the Food Stamp Program in Puerto Rico in early 1975, the only remaining family distribution programs will be on Indian reservations and a few of the outlying territories and possessions.

In addition to food help given to needy households, selected foods were made available by USDA to public and private nonprofit institutions, including nursing homes, senior citizens' centers, "meals on wheels" programs and other charitable organizations which provide food service for needy persons. During calendar year 1974, some 9,900 institutions serving approximately 1.2 million needy persons benefited from Federal food donations. Of these, 2,466 institutions have been identified as serving predominately elderly persons over the age of 65.

Public Law 93–351 (enacted July 12, 1974), which amended title VII of the Older Americans Act of 1965, will have a significant impact on USDA food donations to nutrition programs for the elderly funded under the Act by the Department of Health, Education, and Welfare. This legislation sets the minimum level of donated food assistance to these programs at 10 cents per meal (subject to annual adjustments for increased food service costs) and requires USDA to give emphasis to purchasing high protein foods, meats, and meat alternates. Federal regulations for food distribution were amended in November 1974 to provide that title VII projects will receive foods at the mandated level on the basis of their needs as prescribed by the State agencies which administer the Nutrition Program for the Elderly. Guidelines regarding food donations to title VII projects through cooperating State distributing agencies will be issued in early 1975.

Extension Service

Extension Service programing with and for the aging increased in 1974. Missouri employed a full-time State staff member to provide leadership. Other States continue with a State staff member who provides either full or part-time leadership to programs for the aging. State staff members conduct training for many county staff members. For example, Washington State has trained all county home economists to teach six sessions for the elderly on insurance needs and selection, wills and estates, legal aspects of retirement, the retirement and investment dollar, and how to keep family records. In May 1974, 86 State and Area Family Life specialists devoted a portion of a national workshop to programing ideas for working with the aging.

Training for managers of Nutrition for the Elderly program (title VII) has been conducted by State Extension specialists in Tennessee and other States. Five counties in Washington State trained cooks and managers of the title VII nutrition programs. In many instances Extension home economists are serving on title VII task forces and/or advisory councils.

Connecticut and Pennsylvania Cooperative Extension Services have been funded to develop model educational projects for congregate feeding sites. New York is developing a training model for food service managers.

Extension works directly with groups of elderly and conducts many types of educational programs to improve their quality of living. Below are a few examples of such programs:

—In the area of *safety*, for example, in Texas three retired teachers became qualified instructors for a defensive driving course which 1,005 older Americans completed. Food safety has been taught in group sessions and through mass media including newsletters for senior citizens.

—In the *clothing* area four counties in Washington State have had workshops to help senior citizens with their special clothing needs.

—*Consumer education* is receiving increased emphasis. In Connecticut, five home economists and five Department of Aging staff members are cooperatively conducting a money management program entitled, "you owe it to yourself" for senior citizens. An "estate planning" workshop was conducted in DeKalb County, Tenn., for 32 elderly women and 8 men.

—*Housing* programs are conducted in cooperation with HUD agencies, HEW agencies, and private groups. Connecticut has successfully conducted an education program on "your new home" which is a guide for senior citizens moving into apartments.

—Increasing the *self-esteem* of the elderly has been accomplished in Vincennes, Ind., through a program on "involving senior citizens in meaningful activities." Educational programs on the Cherokee Indian Reservation in North Carolina are designed to help older Cherokees develop leadership abilities through involvement in community activities and through the preservation of their culture and recognition by other North Carolinians of their culture. Over 100 elderly citizens in Union County, N.C., participated in a three-day day camp which resulted in the acquisition of new knowledge, new friends and a feeling of self-worth. Eighty-five counties in Texas honored 176 senior citizens for their civic contributions.

—*Crafts* programs are conducted in many States for leisure time activities as well as for market. As a result of rally day in Orange County, Tex., a thrift and gift shop was opened. One hundred and four senior citizen contributors have derived $5,000 from sales in the shop. In all of Texas, 25 countries have sponsored fairs or bazaars at which 2,000 senior citizens exhibited over 8,000 items and received $9,235 from sales. One hundred counties in Texas sponsored crafts workshops and programs that were attended by 5,721 aging Texans. A prairie craft workshop was established in Woodford County, Ill. Over 60 senior citizens have taught 100 young homemakers skills in crafts since its opening a few years ago.

—*Preventive health education* programs are on the increase for senior citizens. In four counties in Texas, 758 were screened for glaucoma at a savings of over $5,000. In another county, 70 seniors were tested at a free hearing clinic and one case of cancer was detected in its early stages. In another county, 387 had blood pressure testing at no cost. Then in five Texas counties, 660 of the aging population gained beneficial health information; i.e., health frauds, safety, exercise, and prevention of high blood pressure as a result of Extension's education programs.

—*Food and nutrition* programs for the elderly have been conducted in most counties in the United States. For example, 735 elderly persons in Texas were involved in educational programs on the use of food stamps, nutrition, and buying and storing foods.

Paid Extension aides in Maryland and Mississippi are doing one-to-one teaching to help the elderly improve their diets and cope with today's food costs. Patio, balcony, and mini vegetable production is receiving increased emphasis even among the elderly. Five volunteers who were 60 years of age or older in Aurora, Colo., taught 68 young homemakers and 2 men food preservation skills through a series of 6 evening sessions. In 1974, a nutrition education program for the elderly was partially funded by the State Commission on Aging in 13 counties in Texas. A paraprofessional was employed and trained in each county and they conducted a food and nutrition education program for citizens in 34 congregate feeding sites. Evaluations revealed that changes occurred such as these—elderly are drinking more milk, reading labels, are handling food more safely, are shopping wiser, etc.

Extension is endeavoring to *promote better understanding* between the youth and the elderly. For example, in Wisconsin they work together in a drama and art program entitled "creative arts of yesterday."

4-H'ers work with the elderly in nursing homes. For example:

—The Chapman Shamrocks 4-H Club of Dickinson County, Kans., raised money to purchase a water therapy attachment for residents of the Chapman Valley Manor Nursing Home. The 4-H'ers held bake sales, served a banquet and won a radio contest to raise the necessary funds. Then they discovered the nursing home needed help so 36 members volunteered to visit residents and serve drinks and snacks.

—The Bobysoxers 4-H Club of Oswego County, N.Y., assisted in three county nursing homes. They visited patients, planned parties for birthdays and holidays, collected food and provided material and thread for a sewing class.

—The 4-H Council of Brevard County, Fla., surveyed the needs of senior citizens and then planned parties and involved them in a wide variety of recreational activities.

—The Peoria County 4-H Federation Council of Peoria County, Ill., worked with two major elderly programs at the Bel-Wood Nursing Home. The 4-H'ers involved patients in kite flying demonstrations, bingo, singing and talking. They also conducted a homemade ice cream social and played games.

—Members of the DeKalb County 4-H Federation in DeKalb County, Ill., worked with the local FFA chapter to provide a walking trail and picnic area for elderly patients and their families at the DeKalb County Nursing Home.

—The Midland County 4-H'ers of Midland County, Mich., became actively involved with a program of the Town and Country Nursing Home and Pinecrest Farms Nursing Home. The 4-H'ers alternated between the two homes and visited new friends, sang songs, played bingo and did crafts.

4-H'ers promote independent living for the elderly in many States. For example:

—Iowa senior citizens are using their life-learned skills and experiences to teach 4-H members and to train other volunteer leaders. They also serve as key resource people for youth and club leaders.

—Utah's new project holds great promise as a source of well-trained and willing leadership. One of the greatest reserves of untapped talent and ability for bringing new urban youth into the many faceted wonders of 4-H is the senior citizen, aged 60 and over. The pilot projects are a joint venture with the Retired Senior Volunteer Program. These include such efforts as working with girls in tatting, crocheting and drama. In other areas, boys are being taught woodwork.

—In Montana, older Indians of the community are assisting in the bicultural instruction at Rocky Boy Elementary School. While helping the students understand themselves they have also sparked a new community interest in school and education Twelve teachers and 20 teacher aides, most of them Indians, designed the curriculum and coordinated it in all subject areas. Its three key facets are individualized instruction, bilingual (English and Cree) and bicultural (Indian and non-Indian) instruction.

—Montana 4-H'ers helped an elderly woman who came from Austria more than 20 years ago become an American citizen. They tutored her in history, government and citizenship, including the Constitution, and guided her through filing papers. From 25 to 30 young people assisted in the project.

—In New York, when the senior citizens were moved from one nursing home into a new building, 4-H'ers realized the trauma of moving from the original home and assisted by helping to move, visiting more frequently until patients got settled, and keeping up with their crafts activities and parties.

—In Texas, the 4-H council installed blue emergency lights in a window of the homes of 13 elderly people. When the blue light is turned on neighbors know that assistance is needed.

Future plans: As per the working agreement made by the Administrator of ES, USDA and administrators of other Federal agencies on January 13, 1975, the Extension Service will continue to provide educational programs on energy conservation actions for the elderly.

—Extension service staff members will continue to use its information and education outlets and provide information and referral services for older people including Supplemental Security Income, Food Stamps FmHA and HUD programs, health services, the Nutrition Program, title VII, AoA, and others.

—4-H members will be encouraged to become more involved with the elderly. Older persons will be actively recruited to serve as 4-H project leaders.

—Although not the target audience for the expanded food and nutrition education program, aides will continue to reach and teach some of the more isolated and rural elderly.

—The National Extension Homemakers Council and the National Association of Extension Home Economists are active in the National Voluntary Organizations for Independent Living for the Aged. A large number of the 650,000 volunteers in NEHC clubs will engage in programs to provide services to older persons in their own homes or places of residence.

—The educational programs mentioned above and those begun in this decade will be expanded and extended to more elderly persons in 1975.

—In White County, Arkansas, "a 4-H adopt a grandparent" program has been pilot tested and will be launched statewide in February 1975. Its objective to re-establish lines of communication and to help older people feel useful.

ITEM 2. DEPARTMENT OF COMMERCE

FEBRUARY 13, 1975

DEAR MR. CHAIRMAN: This is in further response to your letter of December 20, 1974, concerning Department of Commerce activities which impact on older Americans.

Our report, which is summarized in the enclosed narrative, covers activities in 1974, studies in progress and other activities planned which will be reflected in our 1975 report

If you need further information please let me know.

Sincerely,

FREDERICK B. DENT,
Secretary of Commerce.

[Enclosure]

STATISTICAL RESEARCH, DATA, AND PUBLICATIONS

A paper entitled "Older Americans: Population Projections and Comparisons with the Year 2000" was published in the Fall issue of *Industrial Gerontology*. The paper was prepared by the Bureau of the Census.

The Bureau also continued its regular survey work for other Federal Agencies and added one new survey for the Social Security Administration. Although not bearing exclusively or even primarily on the older population, there are important implications relating to older people in these surveys.

The new survey title is "Survey of Health and Work Characteristics" and was originally conducted in 1972, with a follow-up interview in 1974, of a sample of 18,000 respondents interviewed both years. The study focuses on the impact of the respondent's physical and/or mental disability, if any, upon whether he or she can hold a job, and if so, what conditions (physical, environmental, etc.) may exist on the job; what medical, physical, or occupational services may be required; health expenditures; and financial status.

Following is a list of the other routine surveys related to the aging which the Bureau conducts for other agencies:

Title and Sponsor	*Description*
Health interview survey (HIS) (NCHS)	Data are collected from a total of 42,000 households throughout the year. The information collected is related to acute and chronic health conditions, disability, doctor and dentist visits, and other health related items.
Hospital discharge survey (HDS) (NCHS)	Data are abstracted from sample medical records of patients discharged from 467 short-stay hospitals throughout the United States as part of the National Health Survey program.
Supplemental income survey (SIS) (SSA)	This survey will measure the effects of the Supplemental Security Income Program by obtaining data from a sample of 20,000 individuals before program implementation and resurveying these persons a year later. Information is being collected on work history, health characteristics, housing and community characteristics, and income.
Current Medicare survey (CMS) (SSA)	Data are collected from a monthly sample of approximately 5,000 Medicare recipients and 2,000 persons receiving disability insurance payments. The purpose is to provide SSA with current national estimates on the extent, kinds, and cost of medical services. This is provided on a continuing basis for analysis of the Medicare Insurance Program.
Longitudinal retirement history survey (LRH) (SSA)	This survey is a continuation of a longitudinal study of approximately 11,000 respondents concerning their work history, health, and financial status, and their preparations, plans, and attitudes toward retirement. Data will be collected every other year over a projected 10-year period.
Master facility inventory (MFI) (NCHS)	This survey is conducted every 2 years to maintain an updated file of all facilities in the United States which provide medical, nursing, personal, or custodial care. This file is used as a sampling frame for surveys conducted by NCHS.
Health examination survey (HES) (NCHS)	Personal interviews are conducted in about 10,000 households in selected areas or "stands" to obtain a listing of household members, along with some demographic data, from which a sample of about 12,500 persons are examined for nutritional deficiencies and a sub-sample of 2,500 receive a more detailed clinical examination by PHS medical teams.

The Census Bureau's Current Population Report focusing on certain characteristics of older Americans was not published during 1974 as planned. Tentatively titled "Social and Economic Characteristics of the Older Population, 1974," it is now scheduled for publication in 1975.

The Bureau's Center for Use Studies is continuing its development of a methodology for a geocoded information system to be used to monitor the needs and status of the elderly. The project is still in the first phase, which is a county level system for statewide use. The second phase—a similar system for metropolitan areas—is now pending review by the Administration on Aging.

The Department's National Technical Information Service issued a report entitled "Community Planning for the Elderly." With 534 copies sold to date, this technical report has proved to be one of the most popular NTIS publications.

Two Bibliographies with Abstracts were also issued by NTIS. One bibliography, "The Elderly" (COM-74-11393), contains 139 selected abstracts of research reports submitted to NTIS by major Departments and Agencies of the Federal Government as well as leading private organizations or individuals with Federal grants and contracts. Included are reports which have been put into the NTIS collection since 1964. The reports primarily cover topics on transportation, health care, social services, housing and welfare.

The other Bibliography, "Transportation for the Elderly or Physically Handicapped" (COM-74-10887), contains 25 abstracts of reports on transportation difficulties and design as they relate to the aged or handicapped population. The documents also date back to 1964 and were submitted to NTIS from both Federal and non-Federal sources.

HEALTH CARE, MOBILITY, AND SAFETY

The National Bureau of Standards has provided technical assistance to public and private groups that minister the needs of the aged in the categories of health care, mobility, safety, and personal security. Specifically, this assistance has included the following:

—NBS tests hearing aids each year for the Veterans Administration, whose clientele is heavily weighted toward the aged end of the population spectrum. The test methods developed at NBS and the results are used by other State and Federal Agencies.

—NBS continued its programs in clinical chemistry, dental research, and synthetic implant materials. These programs benefit the aged, who are, proportionally, heavier-than-normal users of the Nation's health care delivery system.

—Older Americans suffer disproportionately from injuries due to falls, and NBS has continued its studies of hazards in buildings—including ramps, stairs, landings, balconies, and floors. The every day environment of the aged will also be made safer as a result of NBS studies of hazards associated with consumer products, such as sharp edges and points, space heaters, and other appliances.

—The aged are particularly vulnerable to crimes against persons and property. To the aged, the home is a haven from these assaults. NBS' technical assistance to the Law Enforcement Assistance Administration in the area of improved standards for door and window security will help make that haven even safer.

—Fixed incomes of the aged make them especially sensitive to the costs of goods and services. Current NBS studies on efficiency labeling of appliances and reports on the economics of energy conservation in the home will affect the aged, much of whose income is devoted to maintaining a place to live.

ITEM 3. DEPARTMENT OF DEFENSE

FEBRUARY 7, 1975.

DEAR MR. CHAIRMAN: This is in reply to your letter of December 20, 1974, requesting information summarizing the Defense Department's major activities on aging during 1974, and plans for continuing efforts in 1975.

The Department of Defense operates one of the most comprehensive retirement planning programs for civilian employees in the Federal Government. The program has been integrated into the overall personnel management process, and is designed primarily to assist employees in their adjustment to retirement and to assist management in planning for replacement manpower needs. It encompasses extensive preretirement counseling for employees and includes trial retirement and gradual retirement options for employees where feasible. This program serves to alleviate many of the problems that employees have encountered in the past when approaching retirement age. Our involvement in this program is expected to continue through 1975 at least at the current level of activity.

We have made effective use of early optional retirement during major reductions in force since the enactment of Public Law 93–39. Under this legislation Federal agencies, or parts of agencies, undergoing a major reduction in force, as determined by the U.S. Civil Service Commission, can be authorized to permit the immediate voluntary retirement of employees who have completed 25 years of service, or who are at least 50 years of age and have completed 20 years of service. Since the enactment of Public Law 93–39 in June 1973, the Defense Department has been authorized to apply these major reduction-in-force retirement provisions for specific geographic areas on six separate occasions, five of which covered time periods extending into 1974. The effect of these authorizations enabled many employees to voluntarily retire and permitted other employees who would have lost their jobs to be offered continuing employment. We expect to continue to request the use of this authority in future major reduction-in-force situations where it will serve to minimize the adverse impact of necessary reductions on our career employees.

During 1974, the Defense components continued to provide multiphasic occupational health programs and services to employees, many of which are designed to address problems generally associated with increasing age. Included were health guidance and counseling, periodic testing for diseases or disorders, immunizations and treatments. Plans for 1975 are to continue to provide occupational health services for employees to the maximum extent possible.

Affirmative action programs for the hiring, placement and advancement of handicapped individuals were implemented throughout the Department of Defense in 1974. An integral part of these programs is emphasis upon in-service placement of employees who, because of increasing age, become impaired or otherwise unable to carry out their duties. It is expected that these efforts will be continued and expanded during the coming year.

As a result of the Public Law 93–259 amendment to the Age Discrimination in Employment Act of 1967, action was taken by Defense components to establish continuing programs to assure nondiscrimination because of age. Responsibility for overall direction and coordination of these programs was assigned to directors of equal employment opportunity, and an information program was undertaken to advise employees regarding administrative procedures under which they could consult with equal employment counselors and file complaints of discrimination if they believed they were discriminated against in employment because of age. Inasmuch as the nondiscrimination because of age program is a continuing one, component efforts in this regard are expected to expand in the future.

The Department of Defense continued its active cooperation with ACTION in 1974 through representation on ACTION's Interagency Coordinating and Liaison Committee for Federal Employee Voluntarism. The campaign which began in 1973 to encourage greater Federal employee participation in community volunteer activities was reemphasized throughout the Department in 1974. This campaign involves employees in off-the-job voluntary contribution of their time, talents and energies to activities within their communities, many of which are designed to provide service and assistance to older Americans. These efforts are expected to continue in 1975.

We appreciate the efforts of the Senate Special Committee on Aging, and we hope that the above information will be helpful to you.

Sincerely,

CARL W. CLEWLOW,
Deputy Assistant Secretary of Defense
(Civilian Personnel Policy).

ITEM 4. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

FEBRUARY 14, 1975.

DEAR MR. CHAIRMAN: Thank you for your letter of December 24. As you have requested, I am forwarding reports from units within the Department of Health, Education, and Welfare for publication in *Developments in Aging*, 1974.

Additional reports from relevant agencies within the Public Health Service are nearing completion and I will be forwarding these to your committee within a week.

Sincerely,

CASPAR W. WEINBERGER,
Secretary.

[Enclosures]

OFFICE OF HUMAN DEVELOPMENT

ADMINISTRATION ON AGING

Calendar Year Report for 1974

A. INTRODUCTION

The year 1974 was a period of transition for the Older Americans Act marking the first full operational year after enactment, on May 3, 1973, of the Older Americans Comprehensive Services Amendments of 1973 (Public Law 93–29). In fulfillment of this new mandate, the Administration on Aging (AoA) has identified two major goals toward which its immediate and long-range efforts will be directed, and its work during the year emphasized these goals.

The first goal is to increase State and Area Agency on Aging capacity to:

—develop and implement annual operational plans to enable older persons to remain in their own homes or other places of residence;
—identify available resources;
—set priorities for action programs;
—coordinate existing service for older persons and pool available but untapped public and private resources for the support of services;
—promote the development of supporting services, such as information and referral and transportation; and
—promote the development of other social services for older persons as defined in the Older Americans Act.

The second major goal is to increase the capacity of the Federal sector to promote comprehensive coordinated services for older persons through coordination of plans and programs which affect this segment of the population. AoA's interagency efforts are being directed at tapping those Federal resources which can be brought to bear in developing and strengthening at the sub-State level a comprehensive system of coordinated services for older people.

Under its new organizational structure, which became effective in 1974, the Administration on Aging is composed of the following constituent units: (1) The Immediate Office of the Commissioner on Aging; (2) the Office of Planning and Evaluation; (3) the Office of State and Community Planning; (4) the Office of Research, Demonstrations and Manpower Resources; (5) the National Clearinghouse on Aging; (6) the Field Liaison Staff; and (7) the Nursing Home Interests Staff.

The Office of Planning and Evaluation (OPE) carried out five-year forward planning activities, various evaluation activities, and legislative and policy analysis functions. OPE's legislative analyses make is possible for AoA to keep advised of bills, hearings, and other phases of the work of Congress, and their effect or potential effect on older persons. In this connection, AoA's legislative staff keeps an up-to-date compilation and analysis of all proposals pertinent to older persons which are introduced in the Congress.

Examples of OPE's policy analysis activities in 1974 included an on-going, in-house analysis of major issues related to the conduct of programs under Titles II, III, IV, and VII of the Older Americans Act, as amended; an intensive, ongoing analysis of the effects of the energy shortage on older persons; an analysis of issues relative to the Supplemental Security Income Program, and other activities under Titles I, X, XIV, XVI of the Social Security Act, in particular, health care services under Medicare and Medicaid. Also initiated was a staff study of the status of social and health services definitions. The in-house study has indicated the need for uniform definitions of services and development of national standards for the measurement of the delivery of such services to assure meaningful assessment of program progress.

The Office of State and Community Programs (OSCP) serves as the focal point for development and assessment of the State and Community Programs on Aging (Title III) and the Nutrition Program for the Elderly (Title VII). It maintains information on programs of other Federal agencies and national voluntary agencies which have potential for relating to State and Area Agency on Aging planning and implementation of services for older people. In addition, OSCP develops regulations, policies, and guidelines for use by State and Area Agencies on Aging; develops optional models and disseminates "best practice" suggestions for use by the Regional Offices, State Agencies on Aging and Area Agencies on Aging; develops and monitors, in cooperation with other AoA units, management information and reporting systems which provide updated information to facilitate planning and program adjustment for management efficiency at all organizational levels; and carries out other related functions.

AoA's Office of Research, Demonstrations and Manpower Resources serves as a focal point for coordination of research on aging by Federal agencies; provides the chairman and secretariat services to the Interagency Task Force on Aging Research, under the Interdepartmental Working Group of the Cabinet-level Domestic Council Committee on Aging; develops policy, supports projects and monitors progress related to research, demonstration, and manpower resources programs under Title IV of the Older Americans Act; and carries out other functions supportive to AoA's mandate to provide national leadership and expertise in encouraging new knowledge and upgrading competencies in the field of aging.

AoA's National Clearinghouse on Aging serves as the focal point within the Federal Government for the collection, analysis, and dissemination of information related to the needs and problems of older persons, and, wherever possible, develops and coordinates programs with other offices and agencies to fill gaps in information in the field of aging; produces a variety of professional and lay publications and audiovisual material on aging; publishes AGING magazine; develops special information campaigns; responds to numerous letters and telephones inquiries; and performs other related functions in the area of public information.

AoA's Field Liaison Staff assists Regional offices in keeping informed of continuing developments relative to the objectives and programs of the Administration on Aging; identifies difficulties being encountered by Regional offices in carrying out their duties and responsbilities; defines priorities and expectations to resolve or prevent conflicting workload demands placed on AoA staffs; ascertains the degree of further assistance required from AoA Headquarters to ensure that Regional offices achieve national and operational planning objectives; and provides other related assistance to Regional office staff.

The Nursing Home Interests Staff, established in 1974 to meet additional responsibilities assigned to AoA in the long term care area, provides technical assistance to community and advocacy groups which are working for the improvement of long term care, assists in the development of new alternatives to institutional care in collaboration with other agencies, serves as project manager for the Nursing Home Ombudsman Demonstration Program, and provides technical assistance in the area of nursing home patient relocation.

In addition to completing its first full operational year under new legislative initiatives and internal organizational arrangements, AoA also completed its first full operational year as a component of the Office of Human Development (OHD) within the Office of the Secretary of HEW. As a part of this new office, AoA has the advantage of working in close association with other OHD components which have responsibilities for the planning and delivery of services for special populations which overlap with AoA target groups, including those of low income and racial minority status.

The remainder of this report provides detailed information relating to activities carried out during 1974 and January of 1975 under the Older Americans Act Amendments of 1973, major program initiatives, and indications of anticipated developments for the remainder of 1975.

B. STATE AND COMMUNITY PROGRAMS ON AGING

In fiscal year 1974, Federal grants to States for area-wide programs of services to older persons were implemented in accordance with Title III of the Older Americans Comprehensive Services Amendments of 1973.

Prior to the Amendments of 1973, the Older Americans Act provided support for discrete services designed to respond to particular needs of older persons in scattered local communities. Under the 1969 Amendments, a program of Areawide Model Projects was initiated to test the viability of providing a network of coordinated service systems to serve older persons. Building upon the most successful experiences of these projects, the 1973 Amendments were designed to develop a national initiative directed toward providing comprehensive systems of services which will coordinate available and potential services and resources on behalf of older persons.

1. *State Planning, Coordination, Administration, and Evaluation*

The Title III Program has as one purpose the strengthening of State Agencies on Aging to discharge, among others, the following responsibilities:

—to become a focal point in the State on behalf of older persons;

—to carry out those activities necessary for effective planning on behalf of older persons, including the establishment of measurable objectives for aging programs;

—to establish such procedures and mechanisms as are necessary to assure the effective coordination of all State planning and service activities related to the field of aging;

—to provide for ongoing monitoring and assessment and to conduct periodic evaluations of activities and projects in the field of aging, with special emphasis on the work of Area Agencies on Aging; and

—to assure, in cooperation with Area Agencies on Aging, the availability of information and referral sources in sufficient numbers so that all older persons will have reasonably convenient access to such sources by the end of Fiscal Year 1975.

To be eligible for grants under Title III, States are required to submit annual State Plans on Aging to the Commissioner on Aging for approval. These plans are developed by the designated State Agency on Aging and submitted by the Governor of each State. Each State Plan must identify the objectives which the State proposes to achieve during the year, and the plans of action which the State will implement for such matters as provision of technical assistance, monitoring of programs, conduct of coordination and pooling activities, provision of manpower development and training, and establishment of information and referral resources. The State Plan must also identify the manner in which the State has been divided into planning and service areas, the determination of which of these areas will have designated area agencies, and the manner in which resources will be allocated under the program.

In 1973 and 1974 State Agencies on Aging conducted Statewide surveys of their older population to determine the concentration of older persons with the greatest social and economic need and to access the availability of resources to meet the identified needs. As a result of these surveys, State Agencies on Aging designated 621 Planning and Service Areas (PSA). By the end of 1974 412 Area Agencies on Aging had been established within PSA's of highest priority to administer Area Plans for comprehensive and coordinated services for older persons.

During 1974, State Agencies' resources were directed toward the implementation of the approved State Plans on Aging for Fiscal Year 1974 and the development and implementation of State Plans for Fiscal Year 1975. The activities under the 1974 State Plans focused on establishing at the State level mechanisms for achieving coordination between Title III and other planning and services programs related to the purposes of the Older Americans Act; establishing State advisory committees on aging; establishing the 412 Area Agencies on Aging, which cover seventy percent of the older population nationally, and approval of area plans on aging developed by these agencies; assisting in the development of agreements for coordinated activities between Area Agencies and the District Offices of the Social Security Administration; developing information and referral sources; and ensuring that at least one-half of the older persons who are recipients of services in areas where Area Agencies are located are those who come within the two primary target groups of this program—the low-income and minority elderly.

State Plans on Aging for Fiscal Year 1975 have been reviewed and approved. Fiscal Year 1975 State Plans include objectives related to the development of State level capabilities for technical assistance to Area Agencies on Aging and nutrition projects under Title VII, and for monitoring and assessment of these programs; the negotiation of formal inter-agency agreements with the Social Services agency in each State; the development of other resources to increase the number of meals served in congregate settings; the establishment of additional Area Agencies on Aging; and the development of information and referral sources which meet standards established by the Administration on Aging. In addition to these efforts, State planning activities include action programs for the involvement of minority agencies and organizations in the delivery of services under Title III and Title VII; steps to assure equal employment opportunities for minorities, women and older people at the State and area levels; and actions designed to assist older persons who face problems associated with the energy crisis.

In Fiscal Year 1974 State Agencies received $12 million for State planning, coordination, administration and evaluation. The President's budget request for Fiscal Year 1975 included $15 million for this activity.

2. *Area Planning and Social Services*

Title III establishes a program intended to address the failure in most communities to systematically pool the resources and services that are available for older persons and to focus them in such a manner as to make a significant impact on the lives of older persons. Title III calls for the development of a national network of agencies which are to be designated by the States as Area Agencies on Aging. The law provides that the State may designate a public or non-profit private agency or organization as an Area Agency on Aging. The State is required, however, to give preference to an established office on aging where one exists.

The majority of the 412 Area Agencies on Aging established in 1974 are located within city or county governments or within regional councils of government. Forty-seven percent are located in rural areas; fifty-three percent in urban areas.

Area Agencies on Aging are required to submit an Area Plan to the State Agency on Aging for approval.

The Area Plans were developed and approved in accord with the following specifications:

—a plan of action for discharging the responsibilities set forth in the legislation;

—an operating plan that will give priority to those activities and services which will assist and benefit low income and minority older persons throughout the planning and service area, and will assure, to the extent feasible, that low income and minority individuals will be served at least in proportion to their relative numbers in the planning and service area;

—a plan for bringing about maximum possible coordination between the resources available in the planning and service area under Title III and those available under the Adult Services and Medical Care Titles of the Social Security Act;

—a plan for demonstrating to local governmental units how the priority established under General Revenue Sharing for social services for the poor or aged can be used in such a manner as to inaugurate new or strengthen existing services for older persons;

—a plan for endeavoring to work out arrangements under which recipients of grants or contracts for nutrition projects mutually agree with the area agency that such nutrition projects shall be made a part of the area's coordinated and comprehensive service system for older persons.

In Fiscal Year 1974, $68 million was appropriated for Area Planning and Social Services. The President's budget request for Fiscal Year 1975 included $76 million for Fiscal Year 1975.

During the 1975–1976 period increasing emphasis will be placed on the monitoring and assessment of the Title III program, as States come closer to meeting their objectives regarding the establishment of Area Agencies on Aging in all priority planning and service areas. A Cumulative Quarterly Progress Report for Older Americans' Act Program has been developed and will be implemented in the States during the last quarter of Fiscal Year 1975. Development of uniform standards regarding the planning and delivery of services to older persons will also be given increased attention.

3. *Statewide Model Projects*

Title III also authorizes the Commissioner on Aging, after consultation with the State Agency on Aging, to enter into contracts with or make grants to any public or non-profit agency or organization within a State to pay part or all of the cost of developing or operating Statewide, regional, metropolitan area, county, city or community model projects which will expand or improve social services or otherwise promote the wellbeing of older persons.

During 1974, $12 million was awarded to State Agencies to conduct Statewide Model Project efforts. State Agencies earmarked over twenty-five percent of the funds awarded to support activities designed to ensure that all older persons will have reasonably convenient access to information and referral sources. These included initiation of Statewide, toll-free WATS lines; expansion and automation of needs and resources survey data; development of interagency information systems for the integration of services; and preparation of manuals and procedural guidelines to train professionals and volunteers in information and referral counseling. State Agencies also earmarked funds for the continuation of SSI-Alert to inform older persons of their potential eligibility for participation in the SSI program. Other activities receiving support included transportation, homemaker, housing, health care, education, legal, day care, and employment services.

4. *Nutrition Program for the Elderly (Title VII)*

Title VII of the Older Americans Comprehensive Services Amendments, the Nutrition Program for the Elderly, was implemented in fiscal year 1974. This Title authorizes the Commissioner on Aging to make formula grants to States to establish and maintain community-based nutrition projects for the delivery of low cost, nutritious meals, served primarily in congregate settings and with supportive social services, to persons 60 years of age or over and their spouses. Each Title VII project must provide at least one hot meal per day, five or more days per week. Supportive social services include outreach, transportation, information and referral services, health and welfare counseling, nutrition education, and recreational activities.

The program is designed to assist communities to meet the nutritional and social needs of older persons who do not eat adequately because: (1) they cannot afford to do so; (2) they lack the skills to select and prepare nourishing and well-balanced meals; (3) they have limited mobility which may impair their capacity to shop and cook for themselves; (4) they have feelings of rejection and loneliness which obliterate the incentive necessary to prepare and eat a meal alone.

The Nutrition Program operates within the same conceptual framework as Title III, since the delivery of low cost meals and related services is one component of a comprehensive coordinated services system. State and Area Agencies on Aging are urged to work out mutually satisfactory agreements with grantees under Title VII designed to integrate the nutrition projects into area service systems, and to bring about meaningful coordination between them and the providers of services under Title III.

The utilization of other public resources is being accomplished through interdepartmental agreements at the national level, including those of the Interdepartmental Task Force on Nutrition, and at the State and local levels. Federal Regulations require maximum utilization by Title VII grantees of all other existing public and private resources in the conduct of the program.

In fiscal year 1974, State Plans for the Title VII program were approved and $98,600,000 was allotted to the States for this program. Six hundred and sixty-five (665) nutrition projects have been approved. Of this number, 72 percent are located in urban areas, and 28 percent are in rural areas. Approximately 220,830 meals are being served daily at some 4,100 sites. According to periodic reports from the States, 64 percent of the meals being served are to older persons below the poverty threshold, and 32 percent are served to minority older persons. These projects vary widely in size and scope of operations.

New funding is available by Public Law 93-351 signed by the President on July 12, 1974 which provided for a three-year extension of the program. A supplemental appropriation bill enacted by the Congress in fiscal year 1975 expanded the funding level of the program to $125 million. In addition $35,000,000 was authorized in the Title III Amendments to the Older Americans Act (Section 309) for the purpose of providing "supportive transportation services in connection with nutrition projects" . . . No appropriations have been enacted for this activity at this time. However, under existing law and regulations 20 percent of the Title VII State allocations may be used for supportive services, including transportation. A number of projects are supporting major transportation activities.

During 1974 States concentrated heavily in getting the projects started and serving meals to older people. Monitoring and assessment of progress toward meeting all of the objectives of Title VII, including the coordination and supporting services aspects of the program, will be emphasized in 1975.

5. *Advisory Councils and Committees*

To actively promote the interests of older persons, establishment of advisory councils and committees at the State and local level is specifically required by the Older Americans Act.

At the State level, State Plans include, as one of their objectives, the establishment of an Advisory Committee to the Governor and the State Agency on Aging. At least one-half of the membership of this committee is to be composed of older consumers of services, including low income older persons and minority group older persons, at least in proportion to the number of minority older persons in the State. Other members are to be representative of major public and private agencies and organizations who are experienced in or have particular interest in the needs of older persons.

At the area level, the Area Agency on Aging is also required to establish an Area Advisory Council. Members are to be representative of program participants and the general public, including low income older persons, and minority older persons at least in proportion to the number of minority older persons in the area. At least one-half of the membership of the Area Advisory Council is to be made up of older consumers of services. The function of the council is to advise the Area Agency on Aging in regard to the development and administration of the Area Plan and activities conducted under it.

For the Title VII nutrition program, States are required to indicate in their State Plans provision for advisory assistance from older consumers of nutrition services and others knowledgeable about nutrition. At the local level, each nutrition project is required to have a Project Council, with one-half of its membership consisting of participants of nutrition services. Other members of the council include persons competent in the field of nutrition services and in the needs of older persons. The project councils have wide responsibilities in all matters relating to the delivery of nutrition services and all policy matters of the project. Where a nutrition project is located within a planning and service area for which an Area Plan has been developed, a representative of the nutrition project council must be included in the Area Advisory Council.

C. FEDERAL COORDINATION ACTIVITIES

The Older Americans Act, as amended, assigns responsibilities to the Administration on Aging to serve as a focal point within the Federal Government in matters pertaining to problems of the aged and aging. In pursuing its broad legislated responsibilities as the Federal focal point for aging matters, AoA seeks:

(1) To improve interagency coordination of plans and programs which affect older persons.

(2) To generate and analyze information pertinent to the problems of the aged and aging.

(3) To assess the progress and problems of programs which affect older persons with a view toward designing new strategies for improved program effect.

(4) To direct initiatives in aging programming and supporting research to meet demonstrated needs of the elderly.

Within the Department of Health, Education, and Welfare, AoA's responsibility for improving Federal coordination and program effectiveness on behalf of the aged is organizationally strengthened by AoA's relationship to the Office of the Assistant Secretary for Human Development. Through that office, AoA is granted organizational responsibility within the Department for advising the Secretary on matters dealing with the aged, recommending actions for improving coordination and government-wide effectiveness, and ensuring that other Department programs also recognize and serve the needs of this special population group.

The current long-range strategy of the Administration on Aging is to direct its limited resources primarily in support of its program management roles under Titles III and VII. In regard to its research, information, evaluation, training and technical assistance functions, as well as in its implementation of the Title III and Title VII programs, AoA attaches high priority to identifying and pursuing those interagency activities which will contribute toward achievement of coordinated, comprehensive services for older people at the local level.

Principal emphasis is being placed upon development of a national knowledge base on aging and coordination of those resources which currently or potentially impact on AoA target group populations. In the near future, priority attention will be directed at improving the delivery and utilization of specific services for the elderly, in particular, the low-income impaired and minority elderly, through joint agreements and programming with SRS, SSA, and PHS, in such areas as I&R, adult social services, Medicaid, rehabilitation services, community health and mental health services, and comprehensive health planning. With additional program experiences and continuing analysis, AoA will be in a position to identify other specific services needed by the elderly which cannot be developed through the State and Area Agency structure alone and which require new Federal initiatives. Barriers to increased cooperative programming will be identified, as well as infrastructural changes and interagency mechanisms and authorities which are necessary to facilitate AoA's full assumption of its broader Federal focal point role.

In carrying out its focal point activities during 1974, AoA has sought to develop the potential for coordinated planning and programming inherent within the Committee on Aging of the Cabinet-level Domestic Council, the Federal Regional Councils, and the Federal Executive Boards. In addition, AoA has built upon previously existing interagency agreements and authorities, and has moved to implement its responsibility within the Department for improving Departmental coordination and effectiveness on behalf of the aged.

AoA believes that significant contributions toward ensuring appropriate attention to the interests of the aged have also been secured through normal review of major issues and proposed legislation and regulations related to Federal activities in such areas as the Supplemental Security Income program, Food Stamps, skilled nursing homes and intermediate care facilities, Federal energy policies, adult education, Medicare, Medicaid, adult social services, rehabilitation services, social security and employment policies for older workers, including the new Community Service Employment Program authorized under Title IX of the Older Americans Act, as amended.

1. *Interdepartmental Committees*

(a) *Domestic Council Committee on Aging.*—The Cabinet-level Domestic Council Committee on Aging, established in 1971, is chaired by the Secretary of Health, Education, and Welfare. The Committee is charged with, among other duties, the responsibility for developing government-wide aging policy. An Interdepartmental Working Group, chaired by the Commissioner on Aging, has been established in order to assist the Cabinet Committee with its work.

During 1974, the Working Group of the Domestic Council Committee established interdepartmental task forces to develop and implement plans for coordinated action programs in the five needs areas of nutrition, research, transportation and energy, I&R, and data collection. To develop and implement these plans, the task forces were convened with representatives from AoA, the Departments of Agriculture, Labor, Housing and Urban Development, Transportation, and Commerce, the Veterans Administration, and ACTION, as well as the Office of Education, Social and Rehabilitation Service, Social Security Administration, and the Public Health Service and the Office of Consumer Affairs within the Department of Health, Education, and Welfare. Other agencies have been involved in coordination activities with AoA on an ad hoc basis. Among these are the General Services Administration, the Office of Economic Opportunity and the Federal Energy Administration.

It is expected that additional task forces will be convened in response to areas of need for interagency collaborative efforts as identified in on-going program analysis and State and Area Agency experiences.

Task Force on Nutrition.—The Task Force on Nutrition has sought to identify and plan for ways in which existing Federal resources can be pooled to (1) increase the number of meals provided to older persons through Federal sources other than Title VII of the Older Americans Act, and (2) provide necessary supportive services to the older persons participating in nutrition programs.

Collaborative agreements in support of these objectives have been completed with HUD, DOT, OE, ACTION, the Department of Agriculture and the Veterans Administration.

Task Force on Research.—The Task Force on Research in Aging has been engaged in a joint effort to develop ways of effectively coordinating Federal research and related activities which concern the older population. As a first step in that direction, member agencies of the Task Force were requested to consider a number of proposed research question areas in terms of their relevance to the research program, interests, and resources of the respective agencies. These research questions share a common focus in that they bear closely on the development of community service networks.

Once member agencies identified those questions which were consistent with their own research program directions, these interests were shared with the educational community and other interested groups and individuals and identified as an initial step in the development of a coordinated, Federal research program in aging.

In a concerted attempt to avoid duplication of research activities members of the Task Force have agreed to support a comprehensive inventory of research in the field of aging. A joint request for proposal is now being issued for a contractor to undertake this task.

Task Force on Transportation and Energy.—During 1974, this Task Force initiated activity in accord with its responsibilities to:

(1) Develop an action plan to implement the Presidential directive that all Federal grants which provide services for older persons also insure that the transportation needed to take advantage of these services is available.

(2) Review the steps that have been taken to deal with the impact of the energy shortage on essential transportation for older persons, to assess the impact of the shortage on the availability and accessibility of transportation services for older persons, and to recommend action programs which help the Federal Government to better meet the transportation needs of older persons.

(3) Develop a series of action programs designed to link existing resources in the area of transportation to the needs of older persons.

A direct result of its activities to date involves a study jointly undertaken by AoA, the Federal Energy Administration, and ACTION to identify and plan for ameliorating the effects of the fuel shortage on volunteer participation in aging programs.

The Task Force on Transportation and Energy has also had particular concern with the conservation of home heating energy and has developed, signed and distributed a joint working agreement in this area. The objectives of the agreement are:

(1) To cooperate in the utilization of existing public resources to assist older persons in the insulation and winterization of their homes.

(2) To take strong advocacy roles in an effort to respond to the ongoing and emergency energy-related needs of older persons.

(3) To provide to older persons clear and accurate information regarding fuel allocation and energy conservation.

Task Force on Information and Referral.—AoA has enlisted the support of fifteen Federal agencies to work in concert toward the objective of making I&R activities at the State and local levels more responsive to the needs of older persons. These Federal agencies have also agreed to monitor and evaluate their progress toward this objective.

Other inter-agency activities in the area of I&R are included in Section G of this report.

Task Force on Data Collection.—Preparatory work to the establishment of a Federal Statistical Task Force on the Elderly within the Interdepartmental Working Group on Aging has begun. This task force is scheduled to have its first meeting in early 1975 and will have as one of its goals an inventory of all Federal statistical data relating to the older population.

(b) *Federal Regional Councils.*—Each Federal Regional Council (FRC) has established a committee on aging in order to accelerate the development of comprehensive and coordinated programs for the delivery of services to older persons at the community level. These committees have sought to coordinate planning and program activities at the Regional Office level and to constructively respond to State and local program coordination problems within each Region.

The committees on aging generally involve representatives of the various departments and agencies with programs directly involved in serving older persons directly or indirectly. Some of the committees also include national voluntary agencies with Regional offices such as the American Red Cross. One or two also include the directors of the State Agencies on Aging in either the full committee or in special subcommittees.

Examples of objectives which the Regions are focusing on include the following: (a) development of a retirement planning program for all Federal employees; (b) reduction of the incidence of crime against the elderly with support from the Law Enforcement Assistance Agency; (c) implementation of the CETA program; (d) an extensive resource directory of Federal resources available to older people; and (e) concentration of Federal assistance in selected sites within the Region where services to the elderly are deficient.

Several regional committees are also using the FRC mechanism to increase Federal agency cooperation with State and area agency programs and in the implementation of the joint working agreements between AoA and other Federal agencies and departments.

(c) *Federal Executive Boards.*—In order to foster Federal-wide involvement in the development of information and referral sources available to all older persons, the Federal Executive Boards (FEB) have identified the development and improvement of such sources as a priority assignment. Accordingly, in each of 25 major metropolitan areas of the country, there is a Federal Executive Board, comprised of the highest ranking officials of each Federal agency in the area, assisting State and Area Agencies on Aging to carry out their I&R responsibilities. FEB involvement has grown out of earlier cooperative activities undertaken among AoA, the Office of Consumer Affairs, and the Office of Management and Budget.

Several FEB task forces have produced or up-dated community directories of services to older persons. Others have begun an effort to coordinate information and referral services. Several are instituting training programs for employees in the FEB member agencies to improve the handling of problems of older persons who may ask the agencies for assistance. Some FEB task forces have instituted community-wide publicity campaigns to encourage older persons to utilize the information and referral services.

2. *Other Interdepartmental Coordination*

In addition to the multilateral cooperative activities pursued through the Interdepartmental Working Group, during 1974 AoA built upon existing bilateral agreements and cooperative arrangements with other Departments and agencies.

Department of Transportation.—DOT and AoA effected a joint working agreement in June which pledged mutual cooperation and coordination in actions designed to achieve increased mobility of older persons by improving their access to public and specialized transportation systems in urban areas. The agreement took note of the fact that DOT set aside $20 million in fiscal year 1975 funds from the Capital Assistance Program to implement Section 16(b)(2) of the Urban Mass Transportation Act of 1964, which provides for capital grants and loans to private, nonprofit corporations and associations for transportation of the elderly and handicapped. Title III, Title VII, and other sources, including general revenue sharing funds, are available for support of operating costs for aging transportation projects.

Department of Housing and Urban Development.—HUD and AoA have jointly supported a program within the National Center for Housing Management to develop a short-term training program and appropriate materials for managers of housing for the elderly. Also to be involved in this program are trainers from a variety of organizations specializing in housing management. These individuals will then be expected to develop additional training under the sponsorship of their respective organizations and thereby establish a national delivery capability for the program.

Efforts were also continued by AoA, HUD, and the Law Enforcement Assistance Administration, in regard to security for the elderly in housing projects. This topic was also chosen as one of the priorities of the Region III, Mid-Atlantic Federal Regional Council Human Resources Committee's Task Force on Problems of the Elderly.

Early in 1975, AoA, HUD will transmit a joint issuance to their respective counterparts at the State and local levels, on the Community Development Program, under Title I of the Housing and Community Development Act of 1974. The joint issuance will include a description of the Community Development Program and accompanying guidance to State and Area Agencies on Aging on ways in which Community Development can be most effective for older persons, with special emphasis on how these funds can be used for the development of senior centers.

Department of Commerce.—An interagency agreement was made with the Bureau of the Census for the Census Use Study group to develop their social statistics system for use by State and Area Agencies on Aging.

Current plans call for the completion of a prototype State system in 1975. A manual and instructions for duplication in other States will be completed sometime in 1976.

ACTION.—AoA and ACTION developed joint program objectives during fiscal year 1974, under which maximum coordination and mutual support between the two programs was pledged. The ACTION objective included the designation of at least one ACTION program designed to provide volunteer opportunities for older persons in each planning and service area for which an area agency is designated and an area plan is approved. In addition, AoA and ACTION agreed to cooperate in the placement of volunteers in nutrition projects supported under Title VII. Under the terms of the joint objective, State Agencies on Aging were also to provide for maximum utilization of senior volunteers and to support and enhance the objectives of the senior volunteer programs.

Based upon findings of an assessment of activites conducted under the fiscal year 1974 joint program collaboration, new fiscal year 1975 joint objectives have been developed and an agreement signed. The new agreement expands the scope of the fiscal year 1974 joint objectives, with greater emphasis placed on joint activities at the State and local levels.

A Joint Announcement of Collaboration Between the Office of Human Development (Office of Child Development and the Administration on Aging) and ACTION/National Older Americans Volunteer Programs was signed in August 1974. The Joint Announcement was distributed to OCD Head Start grantees and delegate agencies, State Agencies on Aging, and Foster Grandparent Program Sponsors and/or Retired Senior Volunteer Program Sponsors. The agreement is designed to promote expanded involvement of older volunteers in the Head Start program. Site visits were made to 5 exemplary Head Start/RSVP programs, after which work began on the preparation of policy and guidance materials for use in developing programs so that additional older volunteers will have opportunities to serve in Head Start programs. These policy guidance materials will be distributed to local programs for their use in working out collaborative efforts at the local level.

Federal Energy Administration.—AoA has attempted to ensure that the special problems of older people are granted appropriate attention in all activities of the Federal Energy Administration (FEA) and its predecessor agency, the Federal Energy Office. In addition to reviewing and commenting upon virtually all energy and fuel allocation regulations and plans, AoA, with FEA, and ACTION, initiated a study of aging programs to determine and plan for ameliorating the effects of gasoline shortages on volunteer participation.

The Federal Energy Administration is participating in the Domestic Council Committee on Aging Task Force on Transportation and Energy. Along with other members of the Task Force, the FEA signed an agreement on energy conservation. The Administration on Aging also participates in the Federal Energy Administration's Consumer Affair Offices' Task Force on Energy and Low Income Persons. Two FEA reports on the impact of the Energy Crisis were also reviewed and commented on by the Administration on Aging.

Department of Agriculture.—AoA and the Department of Agriculture developed an agreement whereby the Department of Agriculture will promptly certify nutrition projects as eligible to accept food stamps toward the purchase of congregate meals in Title VII Nutrition for the Elderly meal sites.

In addition, AoA worked with USDA in the development of regulations to implement Section 707(d) of Title VII, authorized by the 1974 amendments of the Older Americans Act, which directed USDA to donate surplus commodities to Title VII at a level of not less than 10 cents per meal. These regulations were published in the fall of 1974 and AoA has worked with USDA since then in the development of guidelines for this provision, and in briefing Regional and State staffs on the operations of the commodity program.

Department of Labor.—The Administration on Aging has worked closely with the Department of Labor in its development of regulations for implementation and operation of the Comprehensive Employment and Training Act of 1973 (CETA) and for the Senior Community Service Employment Program authorized by Title IX of the Older Americans Comprehensive Services Amendments of 1973. The State and Area Agencies on Aging have also been encouraged to take an active role in the implementation of these programs. Technical assistance material has been developed and transmitted to the State and Area Agencies on Aging on the possible actions that can be taken to ensure that the employment-related activities of the Department of Labor and the State and Area Agencies on Aging are coordinated, and the older persons' needs are considered in the development by manpower prime sponsors of comprehensive manpower plans.

Also, information has been provided on the availability of funds under the Emergency Job Program under the Comprehensive Employment and Training Act program, and State and Area Agencies on Aging have been urged to work with manpower prime sponsors to ensure that older persons are included among the persons hired under the program.

In addition, the Department of Labor under an agreement with AoA is currently working on a study to enable the Administration on Aging to carry out its responsibility for appraising existing and future personnel needs in the field of aging. Details of this study are presented in Section E.

Civil Service Commission.—In order to help insure that State Agencies are engaged in meaningful affirmative action activities, AoA and the CSC agreed to make joint visits to State Agencies on Aging for the purpose of assessing State Agency progress. A written agreement to this effect was finalized and transmitted to the field in November.

3. *Intradepartmental Coordination*

The Administration on Aging has been intensively involved in the development of a series of formal agreements with various agencies within the Department of Health, Education, and Welfare, especially, SRS, PHS, and SSA. These efforts are designed to improve coordination of State and community activities in the areas of information and referral, adult social services, rehabilitation services, community health and mental health services, and comprehensive health planning. Building upon cooperative arrangements pursued during 1974 these formal agreements will reflect AoA's commitment to identify and plan for ways in which Departmental resources can be brought to effectively focus upon the needs and interests of older persons.

Social Security Administration.—AoA has continued to work with SSA on the establishment of Information and Referral Services for older people and on the dissemination of information concerning the Supplemental Security Income Program. A comprehensive discussion of I&R activities is presented in Section G. AoA has reviewed and commented on virtually all regulations pertaining to the SSI program and in collaboration with SSA, developed and implemented a special project called "SSI-Alert" to inform potentially eligible older people about the SSI benefits and options. "SSI-Alert" is discussed in Section H of this report.

Public Health Service.—AoA has been working to update a joint agreement with the PHS under which joint efforts have been focused on cooperative funding of research and demonstration grants, health technical assistance to areawide model projects formerly funded by AoA, planning for long-term care and alternatives to institutionalization, and development of objectives for joint action in health planning. AoA has also consulted with PHS components, namely the Health Services Administration, Health Resources Administration, and the Alcoholism, Drug Abuse, and Mental Health Administration, relative to the cosponsorship of selected evaluation projects.

A second joint working agreement has been signed and distributed by the Administration on Aging and the Public Health Service which has as its objective the improved delivery of coordinated health and social services. The agreement is designed to bring about greater coordination between the resources available under the Public Health Service Act and the resources available under Titles III and VII of the Older Americans Act, through joint planning, programming and implementation at the Federal, State and local levels. Specific appropriate activities for coordinated action are noted in the agreement.

AoA has also worked with PHS components and the HEW Office for the Handicapped, formerly the Office of Mental Retardation Coordination, to identify problems of mentally retarded patients in nursing homes. AoA and PHS staff also worked with the Division on Aging of the National Association of State Mental Health Directors to try to effect cooperation with State Agencies on Aging.

Office of Nursing Home Affairs, PHS.—During 1974 AoA was assigned additional responsibilities in the area of long-term care, and met regularly with staff of the Office of Nursing Home Affairs to coordinate long-term care-related activities, especially in the matter of improving the quality of institutional care. In these activities, AoA has served as a member of an Interagency Advisory Group, whose other members include representatives from the Office of the Assistant Secretary for Health, the Office of Nursing Home Affairs, the Social Security Administration, the Social and Rehabilitation Service, the Public Health Service, and the Office of Fire Safety Engineers.

In July of 1974 seven Nursing Home Ombudsman Demonstration Projects were formally transferred from PHS to AoA. Accordingly, to meet this and other new responsibilities related to nursing home concerns, AoA has recently added a Nursing Home Interests unit to its staff. The functions of the Nursing Home Interests Staff are discussed in Section A of this report.

Office of Education.—AoA has cooperated with the OE Bureau of Libraries and Learning Resources on a demonstration project utilizing libraries as information and referral centers. In cooperation with the Bureau of Adult, Vocational and Technical Education, AoA has also fostered the cooperation of State Supervisors of Home Economics Education as a resource in the nutrition education program mandated under Title VII of the Older Americans Act.

An agreement signed in January 1975 between the Commissioner on Aging and the Commissioner of Education encourages the expanded use of public school facilities for serving meals to older people. Included in this agreement is provision for a variety of educational, recreational, cultural and other community services and volunteer opportunities for older people.

AoA has also worked with the Bureau of Adult Education to ensure that the educational needs of older adults are more adequately considered in special projects funded under the Adult Education Act.

Social and Rehabilitation Service.—AoA and SRS have agreed to co-sponsor selected program evaluation studies directed at assessing long-term care alternatives and the development of non-vocational rehabilitation goals for older people.

Agreements have been developed with the Community Services Administration (CSA), Medical Services Administration (MSA) and the Rehabilitation Services Administration (RSA).

The agreement with CSA, which is about to be signed, focuses on bringing about maximum possible coordination between the resources available under the Social Security Act and the programs under Title III and Title VII of the Older Americans Act to provide social services to older persons.

An agreement with MSA has been signed and transmitted to the field which has as its objective the improved delivery of coordinated health and social services for older persons. The agreement is designed to bring about greater coordination of resources available under the Medical Assistance Program and Title III and Title VII of the Older Americans Act.

An agreement with RSA has been signed by AoA and is currently under final review by the Commissioner of RSA. This agreement establishes a joint working relationship to improve delivery of coordinated health and social services for impaired older persons. The agreement is intended to provide a framework within which to structure joint efforts on consultation and sharing of expertise, planning and implementation of coordinated service delivery programs and recommendations for future program directions.

D. RESEARCH AND DEMONSTRATIONS

1. *Research and Demonstration*

The Administration on Aging's research and demonstration program supports projects which add to existing knowledge in a variety of areas which are critical to the development and improvement of aging programs. The primary source of funding for R&D projects in aging is Title IV-B of the 1973 Older Americans Act Amendments. Under the fiscal year 1974 appropriation of $7 million, 119 new and continuing projects received financial assistance. The President's budget request includes $7 million for this activity in fiscal year 1975.

The new projects were developed in response to a carefully planned research and development strategy which focused on directing research toward knowledge critical to effective conduct of new programs mandated by Titles II, III and VII of the Older Americans Comprehensive Services Amendments of 1973. The new projects described below are primarily directed at generating knowledge critical to effective management and coordination of the comprehensive service networks mandated by Title III of the Older Americans Act. To that end, certain research tasks with this focus which were presented in the fiscal year 1974 strategy yet remain to be undertaken. These are being incorporated into the fiscal year 1975 research program which is currently being planned and developed.

Continuation projects are those which were initiated prior to July 1973 and received additional Title IV–B support with fiscal year 1974 funds. These complemented the new emphasis on planning and coordination by continuing the search for new knowledge and experience on approaches and services designed to enhance potential for satisfying independent living and reducing the need for institutionalization among the elderly.

(a) *New Awards.*—The following summary of the new start research projects is organized under the five goal headings of the 1974 Research and Development document.

Goal I: Coordination. *To anticipate problems in and seek practical approaches to facilitating coordination of planning and delivery of community services for the elderly by State and Area Agencies on Aging funded under Title III of the Older Americans Act of 1965 as amended.*

As goal I suggests, the main thrust of AoA planning and programming is the development, primarily through the efforts of State and Area Agencies on Aging, of comprehensive and coordinated service systems for older persons. A comparable level of priority within AoA's research program was given to the analysis of the coordination process, the factors which tend to promote or, in other instances, impede effective service coordination.

Four new project grants bear directly on these research objectives, as indicated:

—Both the Yale University School of Medicine and Portland State University received awards to develop conflict resolution models which will be compared and tested against actual community settings for planning and service networks.

—The University of California at Berkeley will investigate staff, organizational, and community characteristics of Model City programs for evidence of factors which correlate with successful (or unsuccessful) coordination of services.

—The School of Social Services Administration, University of Chicago, now has underway an analysis of conflicting government regulations, policies and guidelines related to aging, leading toward suggested methods for resolving jurisdictional conflicts and untangling legal snarls by either discretionary administrative action or model legislation.

The Title III program also places considerable emphasis at both the State and area levels on making information and referral services accessible to older persons and on integrating these I&R sources within a comprehensive, coordinated service system. The following four research contracts have been undertaken with fiscal year funding to provide a firmer knowledge base for the future development of I&R service systems:

—Applied Management Sciences (Silver Spring, Md.) has been awarded two contracts: the first to assess the organizational structure and interaction of information and referral service programs; the second to compare from the viewpoint of service recipients and providers the relative benefits of age-segregated versus age-integrated I&R systems.

—Cooper and Co., located in Stamford, Connecticut, is developing cost-effectiveness models of information and referral to be presented in the form of a reference manual for potential use by State and Area Agencies on Aging.

—The Health-Welfare-Recreation-Planning Council in Norfolk, Virginia, has received a contract to describe the operation and document the findings to date of an automated community services information system functioning within the Norfolk and Tidewater, Virginia area.

Goal II: Financial Support. *To ascertain the feasibility of, and practical approaches to, ensuring that Federal financial resources earmarked or available for the provision of services to older persons under diverse federally supported programs can be so interrelated as to be directly supportive of the coordination efforts of State and Area Agencies on Aging.*

A grant to the Andrus Gerontology Center, University of Southern California, will pursue important dimensions of this subject, and result in two research products as indicated:

—A report identifying and analyzing those funding regulations, program requirements, and management procedures which impede the pooling of resources on behalf of the elderly.

—A text or manual to assist State and Area Agencies on Aging in dealing with Federal, State, and local regulations, requirements, and procedures as they attempt to combine available resources in carrying out Title III of the Older Americans Act.

Goal III: Needs of Low-Income and Minority-Elderly. *To ensure that the development of comprehensive and coordinated service systems for older people address the particular needs of the low-income and minority elderly, the priority target groups of the Title III program.*

AoA planning places priority emphasis on encouraging the development and provision of services needed by those elderly least able to influence such development, i.e., the low-income and minority elderly. Identifying these target populations is crucial to effective planning and guidance of the Title III program to bring about measurable beneficial impact on the status of low income and minority older persons.

The following five grants were made to conduct research addressed to these target populations:

—The University of Illinois at Chicago Circle will conduct a national survey to provide detailed information on the needs of older people, particularly as these relate to social integration, community services and health and specialized housing.

—The Rand Corporation, Santa Monica, California, will support a review of literature and analysis of census data aimed at identifying the status of Black, Puerto Rican, Chicano, Native Americans, and Asian elderly in relation to the aged in general.

—The Institute for Research on Poverty, University of Wisconsin, will develop definitions of "adequate income level" for categoric groups of elderly, and descriptions of multiple factors, besides lack of income, which contribute to poverty in old age.

—The University of Southern California at San Diego will identify special characteristics of different aged minority groups which call for special types and methods of service programs.

—Case Western Reserve University, Cleveland, Ohio, will determine whether and to what extent certain economic and service incentives can induce and equip family units to provide home care for elderly members.

Goal IV: Needs and Market Demands. *To provide a sound knowledge of the characteristics, needs, problems, and general expectations of older persons that will permit the formulation of policies, and programs that will more effectively strive toward the national objectives for older Americans specified in Title I of the Older Americans Act of 1965 as amended.*

Under this goal, AoA supports research of a more fundamental, long-range nature which is especially suited to AoA's responsibility as the Federal focal point for aging matters.

Five projects of this nature were funded, as indicated:

—Catholic University of America, Washington, D.C., has been awarded a grant to develop models depicting decision-making patterns of older persons in their use of available resources and show the effects of ecological, psychological, and biological factors on these patterns of decision making.

—A contract to Lawrence Johnson and Associates of Washington, D.C. will provide information on the service consumption, patterns and priorities of the aging through a literature search and sample survey.

—A grant to the Wilmington Housing Authority, Delaware will support a literature search of current knowledge about the causes and effects of social isolation among the elderly. An analysis of community programs focused on combating social isolation will also be undertaken.

—A grant to the International Center for Social Gerontology, Washington, D.C., will provide a comprehensive literature review on congregate housing for the elderly, placing special emphasis on European experience in this field. The grant also aims at a systematic analysis of the environmental, economic, cultural and other factors that favor success of such programs, with implications for legislative and administrative action concerning congregate housing programs in the United States.

—Grant research by the Center of Demographic Studies, Duke University, Durham, N.C., will indicate what combinations of factors cause older persons to adopt independent, congregate, or institutional patterns of living arrangement.

Goal V: Development, Organization, and Delivery of Services. *To ensure that the coordinated and comprehensive services developed in whole or in part under the aegis of the Older Americans Act are structured and delivered in such manner as to maximize the utilization of existing resources, reflect the needs of the recipients, and recognize special problems of sub-populations of older persons.*

Four projects were funded under this goal, as follows:

—The California Office on Aging has a grant to identify the characteristic problems and needs of rural older persons, and to assess the scope and effectiveness of typical rural service systems.

—The Virginia Polytechnic Institute and State University has a grant to develop economic models of rural service delivery systems, focusing on communications and transportation cost elements.

—The School of Social Service Administration, University of Chicago, has initiated research on a series of models that show the effects on older persons of a wide range of service delivery methods.

—The Human Resources Corporation, San Francisco, California, has a contract for research in the area of advocacy in the field of aging, on the part of both organizations and individuals.

(b) *Continuation Projects.*—The continuation projects largely focus on better ways to help the vulnerable elderly return to or remain in their own homes or other appropriate settings. A number of these projects are described below in order to illustrate the wide variety of areas within which investigations and new knowledge on behalf of older persons are being undertaken. A number of these projects receive support from other Federal agencies, in addition to the Title IV funds provided by AoA.

—Building on substantial research in progress, the Office of Elder Affairs in Boston proceeded with a demonstration of community-based home care programs of coordinated health, social and other support services.

—A program sponsored by the Chinatown-North Beach Health Care Planning and Development Corporation in San Francisco is directed at three ethnic minority groups—Chinese, Filipino and Italian.

—The Levindale Hebrew Geriatric Center and Hospital in Baltimore is exploring potential changes in Medicare-Medicaid legislation which underwrites health care predominantly within an institutional setting.

—The Burke Rehabilitation Center in White Plains, New York, has a project focused on day care services within the context of total community services linked to an information and referral system.

—Montefiore Hospital in New York City is evaluating day care services with support from these same sources.

—The Colorado Department of Institutions, Denver, is testing the feasibility of specialized boarding homes for elderly persons who have had or continue to have mental problems.

—The Family Service Association of America is attempting to strengthen the quality and expand the scope of programs for the aging in local family services agencies, with the overriding objective of enhancing programs which enable the elderly to remain in their own homes.

—A manual for training homemakers in home care for the elderly has been developed by the National Council for Homemakers Services.

—The National Center for Voluntary Action has been developing program guides for voluntary organizations to use in establishing home service programs for the elderly.

—The National Interfaith Coalition on Aging, Athens, Georgia, examined programs for the aging and information systems about services for the elderly, with the goal of improving coordination of public and private efforts for the older adult population.

—The potential for translating electronic and technological advances into care for the elderly is being examined by the Illinois Institute of Technology.

—Inter-Study of the American Rehabilitation Foundation is investigating the potential for use of cable TV in an information and referral system.

—Interstudy of Minneapolis continued a research project to develop a model for Statewide networks of information and referral centers and a series of manuals designed to guide other communities in establishing and operating such centers.

—The Wisconsin Health and Social Service Department tested the above model in 13 sites in rural and urban centers.

- —The Human Resources Department of the State of Georgia is testing a Statewide "Tie-Line" information and referral project which incorporates several specialized activities such as consumer information and drug and alcohol information.
- —The Massachusetts Department of Elder Affairs is experimenting with a Nursing Home Ombudsman program to improve the quality of care received by patients within nursing homes.
- —Montefiore Hospital in New York City has evaluated the effectiveness of brief psychotherapy to the bereaved aged.
- —The New York State Department of Mental Hygiene has been developing refined measures for the detection of psychopathological conditions in the elderly and identifying implications for treatment.
- —The University of Chicago has developed a psychological instrument for measuring personality characteristics in middle-aged and older people.
- —The Montana United Indian Association is studying the nature, type and extent of problems and of needs common to elderly urban Indians.
- —The University of Pennsylvania is assessing the impact of elderly people of the 1972 flood damage in Wilkes-Barre and the responsiveness of service agencies to the crisis.
- —The Oregon State Legislative Indian Committee on the Aging developing a legislative strategy to meet the service needs of the elderly identified by the White House Conference on Aging which are not currently being met by existing programs.
- —The University of Southern California Gerontology Center has organized, evaluated, and analyzed research data, concepts, theories and issues on the biological, psychological and social aspects of aging for publication in three *Handbooks in Gerontology.*
- —The Gerontological Society is developing state-of-the-art papers on key social policy needs, possible alternative solutions and the kinds of research, development and information that would be useful in making policy decisions responsive to such needs and issues.
- —The Stanford Research Institute is exploring national policies affecting the elderly and predictions for the future, based on alternative policies.

(c) *Projects To Be Supported by Fiscal Year 1975 Funds.*—Of the Fiscal Year 1974 projects, approximately 30 will be continued in Fiscal Year 1975. In Fiscal Year 1975, AoA plans to additionally support approximately 50 research and demonstration projects.

Anticipated Fiscal Year 1975 Funding

The anticipated Fiscal Year 1975 funding is $7 million. Pre Fiscal Year 1974 new starts, 23; Fiscal Year 1974 new starts, 7; estimated Fiscal Year 1975 new starts, 50; and total estimated research and demonstration projects, 80.

The Fiscal Year 1975 new starts will respond to a research strategy designed to support AoA program goals. AoA will fund research and demonstrations projects which will:

- —Assist in identifying and understanding those processes of aging uniquely associated with or inherent in the make up of the elderly. Such knowledge will permit the development and implementation of programs responsive to the capabilities and functionings of the elderly.
- —Provide knowledge of characteristics, attitudes, behaviors and distributions of older persons. Such knowledge will permit formulation of policies and programs which will facilitate the achievement of equal opportunity and access to the objectives specified in Title I of the Older Americans Act of 1965 as amended.
- —Provide knowledge and understandings of social, economic, and environmental forces which impinge on the ability of the elderly to secure and maintain "freedom, independence and free exercise of individual initiative in planning and managing their own lives."
- —Provide knowledge descriptive of intervention mechanisms and the responses of the elderly to those interventions. Such knowledge will provide the understandings necessary for the development, organization and delivery of service, as well as, the coordination of delivery systems as supported under Titles III and VII of the Older Americans Act of 1965 as amended.

Dissertation Fellowship Program: AoA will implement a dissertation research fellowship program which will seek to encourage research in the field of social gerontology and related areas. The program's goal is to gain new insights into the needs, circumstances, resources, expectations, and roles of the nation's older population, including the following research activities:

—Identifying and assessing patterns, conditions, and new approaches which contribute to a wholesome and meaningful life for older people.

—Developing and evaluating new approaches, methods, and techniques for improving coordination of community services for older persons.

—Collecting and disseminating information concerning research findings and other materials developed in connection with activities under the Older Americans Act.

2. *Model Projects of National Scope*

The Model Projects program provides support for projects designed to develop, test and display better ways to promote the well-being of older persons by increasing both the scope and quality of services. Authority for this program is provided under Title III, Section 308 of the Older Americans Act Amendments of 1973. The program is administered by the Division of Research Applications and Demonstrations. Fiscal Year 1975 appropriations total $5.0 million.

In making awards, special consideration is given to applications which: (1) assist in meeting the special housing needs of older persons; (2) provide continuing education to older persons; (3) provide pre-retirement education, information and related services to the elderly; and (4) provide services to assist in meeting the particular needs of the physically and mentally impaired older person including special transportation and escort services, homemaker, home health and shopping services and other services designed to assist such individuals in leading a more independent life. It is anticipated that Fiscal Year 1975 funds will also support some projects designed to elicit effective ways to help older persons to better cope with the economic pressures of recession and inflation.

In Fiscal Year 1975 approximately forty model projects will receive support. Of these, most will be funded in the special emphasis areas noted above. Examples of previously funded projects follow.

In the area of housing, a project in North Carolina is directed at increasing the number of older persons receiving housing assistance through: (1) Advising older persons on the rental housing market; (2) making referrals to subsidized housing programs; (3) counseling homeowners on housing rehabilitation and identifying and applying resources for housing repairs; and (4) counseling older persons who wish to buy housing and assisting in applications for mortgage programs.

In the field of education, six Minnesota educational institutions have formed a consortium and are developing and operating a replicable model of a Statewide network designed to make continuous, lifelong learning of high quality available to older persons and those serving them.

In the area of pre-retirement planning and preparation, the Duke University Medical Center, North Carolina, is developing a planning-counseling model and a critique of pre-retirement training models. Included is a study of the effects of pre-retirement training in different socio-economic groups.

In assisting the physically and mentally impaired older person, the Papago Indian Tribe of Arizona, the Inter-Tribal Council of Nevada and the Gila River Indian Community of Arizona, are using Indian homemaker health aides and outreach aides to demonstrate ways to improve the health, living conditions and social involvement of aged reservation residents. In addition, the New York City Office for the Aging is demonstrating particular approaches to better meeting the needs of mentally frail older persons.

In information and referral, the New Life Institute, New York, is establishing a national clearinghouse for private, non-profit community agencies specializing in job placement services for the aging.

In accordance with the Administration on Aging's policy to reduce natural disaster-related problems for older persons, State Agencies on Aging in Alabama, Kentucky, Tennessee and Indiana were granted awards to provide extensive outreach and follow-up services, after recent natural disasters. These activities are discussed further in Section II of this report.

E. TRAINING

Under the new Title IV–A of the Older Americans Act as amended, AoA is authorized to help meet critical shortages of adequately trained personnel for programs in aging by: (1) developing information on the actual needs for personnel to work in the field of aging, both present and long range; (2) providing a broad range of quality training and retraining opportunities, responsive to changing needs of programs in the field of aging; (3) attracting a greater number of qualified persons into the field of aging; and (4) helping to make personnel training programs more responsive to the need for trained personnel in the field of aging.

The Fiscal Year 1974 appropriation for this activity was $9.5 million.

The following manpower and training activities were in progress in 1974.

1. *Career Education in Aging*

Career training programs sponsored by the Administration on Aging were underway at 47 institutions during the 1973–74 school year. These included 34 programs which offered interdisciplinary education with specialization in gerontology, and 13 awards which were made to schools of social work to prepare students for community development to meet the needs of the older population. Approximately 400 students received traineeships from Fiscal Year 1973 funds for education in the 1973–74 academic year (training grants are forward funded).

Since the inception of the program, most of the career training has been offered at the graduate level. In 1974, career support was provided for training at the baccalaureate as well as the masters and doctoral levels. The objectives of this career development program are to prepare practitioners for State and Federal program planning and administration, community development and coordination, management and administration of retirement housing and homes for the aged, senior center direction, teaching and research, and for serving older people through adult education, architectural design, counseling, law library service, recreation, and other relevant fields.

Each career-oriented training program included an intensive practicum of three to nine months. Students and graduates have demonstrated to program agencies the value of personnel who have systematic knowledge of the aging processes and of older people. An evaluation study commissioned by AoA during the 1973–1974 period showed that over 60% of all recipients of AoA traineeship awards prior to September 1972 are currently employed in aging or aging related jobs.

Administration on Aging supported career training programs have from their inception sought to recruit students from all minority groups. During Fiscal Year 1974, eight programs were in operation at minority institutions or other institutions with programs specifically focused on minority students. Approximately 22 percent of the students being supported were from minority groups.

For the 1974–75 academic year, educational institutions which supported career training programs in 1973–74 are operating under one year continuation grants from Fiscal Year 1974 funds. These funds are being used primarily to support existing programs in gerontology, including student support based on need as determined by the university. Approximately 4600 students are enrolled in aging courses and programs at these AoA supported training institutions; 625 of these students received financial assistance as part of the Fiscal Year 1974 career training grant awards.

2. *Short-Term Training*

AoA has supported a number of short-term intensive training programs which have provided skills to several thousand persons recruited from all parts of the country. With the implementation of Titles III and VII a great many newcomers have been attracted to the field of gerontology. Upgrading of competencies has also been required by many persons who were already in the field of aging prior to the passage of the 1973 Amendments to the Older Americans Act but were given new responsibilities under that legislation. During 1974 support for short-term training was expanded to meet these needs. Examples of short-term training activities include the following:

—An award was made to Syracuse University to develop six seminars to train, by the end of Fiscal Year 1975, 170 State Agency Executives and key staff in leadership roles and responsibilities that derive from the broad mandate of the Title III legislation.

—In the area of nutrition, grants were awarded for continued support to five programs where nutrition program training was already underway.

—Funds will be used primarily to provide technical assistance to State Agencies on Aging to prepare additional trainers in nutrition by providing updated knowledge about Title VII operations. In addition, Oregon State University will continue to develop, collect and disseminate nutrition materials.

—The Assistance Group, Inc. of Silver Spring, Maryland was awarded a contract to train, by February 1975, approximately 75 State Agency personnel in techniques of providing technical assistance to persons at State and local agencies who are responsible for meeting the Administration on Aging's requirements for Information and Referral programs.

To supplement the short-term training activities undertaken to prepare State and Area Agency personnel and nutrition project staff, additional Fiscal Year 1974 funds were awarded to State Agencies on Aging for training and manpower development activities at State and local levels which are not addressed by the national training efforts, but are necessary for effective implementation of the 1973 Amendments.

Grants were awarded to ten colleges and universities to conduct symposia for faculty members and others who will be offering courses related to the needs of older persons as part of state short-term training programs. The symposia will present current information on training materials and methods, as well as information related to programs under the Older Americans Act. These symposia are expected to complement other Administration on Aging training and manpower development initiatives.

3. *Manpower Development*

In accordance with Sections 402 and 403 of Title IV–A efforts are being supported to assess present and future manpower needs in the field of aging and to increase the range of professional and vocational skills available to serve older persons.

The Department of Labor under an agreement with AoA is currently working on a study to enable the Administration on Aging to carry out its legislative mandate to appraise existing and future personnel needs in the field of aging and to report on the nation's capability to meet those needs. The DOL study is divided into two phases as follows: (1) An analysis of current and projected manpower needs, by occupation, in nursing homes with an analysis of future supply-demand conditions for several professional occupations important to the field of aging; and (2) an analysis of the key questions AoA must consider in the development of a long range strategy to carry out its manpower-related responsibilities.

Examples of other grants made by AoA with Fiscal Year 1974 funds pursuant to its responsibilities in the areas of manpower development and training include the following:

—Two projects which are designed to attract artists to the field of aging in order to make artistic activities more available to older persons.

—A project which is designed to serve as a national model for programs which have as their objective recruitment, training and job placement for older persons in the area of health-related services for the aging.

—A project to upgrade the training of American Indian para-professionals working with the elderly American Indians.

—A program designed to train operators of family care homes for older persons in Kentucky, where such homes have recently come under the provisions of State-wide licensing requirements.

—As of December, 1974 funding of the National Center for Housing Management has resulted in the training of 241 managers of housing for older persons and 7 trainers in this field. By the end of fiscal year 1975 it is anticipated that 1000 housing managers and 20–30 trainers will have been trained.

4. *Conferences*

A number of grants were made to assist in training persons who are employed or preparing for employment in the field of aging through seminars, conferences, symposia, and workshops to facilitate exchange of information and to stimulate new approaches with respect to activities related to the Older Americans Act. Support was provided for the following activities:

The Sixth Biennial International Senior Citizens Congress, International Senior Citizens Association, Inc.

National Conference on Reducing Crimes Against the Elderly, American University, Washington, D.C.

Conference of Legal Services Projects, National Senior Citizens Law Center, Los Angeles.

National Conference on the Spanish Speaking Elderly, National Chicano Planning Council, Inc., San Jose, California.

Gerontological Conference on Mental Retardation, University of Michigan.

Meetings with the Institute for Operational Research, Tavistock Institute, London-Duke University Center for the Study of Aging and Human Development.

International Congress of Gerontology in Israel-Gerontological Society.

Support for Black Educators Council for Human Services (BECHS)-North Carolina A&T State University, Greensboro, N.C.

5. *Other Special Projects*

During 1974 the American Association of Community and Junior Colleges (AACJC) completed its activities undertaken with AoA funds.

The grant produced two items which have already been distributed by AACJC to all 1100 community colleges, and by AoA to all State and Area Agencies and others on request. The two documents produced were based on a survey of the 1137 community and junior colleges and technical institutes that was undertaken in October, 1972 and updated in March, 1974.

(1) *Older Americans and Community Colleges: An Overview.*—Provides an inventory of aging programs and services offered by community and junior colleges in the area of—

Manpower training programs	40+
Retired senior volunteer programs	26
Retirement education programs	140
Cultural enrichment courses	340
Free or reduced tuition	160

(2) *Older Americans and Community Colleges: A Guide for Program Implementation.*—Provides a great many specific suggestions on what programs and services can be offered and how to go about developing such programs, including an appendix that contains outlines for individual courses eg. Homemaker-Homehealth Aide Course, as well as outlines for developing Associate Degree and Certificate Programs.

The Adult Education Association (AEA) completed a study which was supported by AoA in fiscal years 1973 and 1974. The subsequent report, *New Learning for Older Americans: An Overview of National Effort*, is based on interviews with experts, a literature analysis, and 3500 responses to a questionnaire sent out in January and February, 1974.

The report will be published and distributed by the Adult Education Association. It is expected that the document will generate increased interest in adult learning among the education agencies, the libraries, museums, and Cooperative Extension Service, as well as other community agencies having a potential role in adult learning.

The need for substantive staff development for Administration on Aging personnel is being addressed through the use of S&E funds which were available to AoA in fiscal year 1974. A contract was awarded to E. H. White Inc. for the development and delivery of a curriculum for all Central and Regional Office staff in 1975.

F. EVALUATION

The AoA Evaluation Plan for fiscal year 1974 stressed the need for information on the elderly and services to the elderly at the national, regional, State, area, and project levels. It was designed to initiate the conduct of studies related to the overall effectiveness of AoA policies and programs and to their impact on the aging population, rather than to evaluation of individual grantee management performance.

The fiscal year 1975 Evaluation Plan stresses the evaluation of the major AoA programs: the Area Planning and Services Program, Nutrition Program for the Elderly, and Information and Referral. Contracts for these evaluations will be let in the fourth quarter of fiscal year 1975.

In support of these plans AoA had, by the end of 1974:

(1) Developed a request for proposal for a longitudinal evaluation of the Title VII, national Nutrition Program for the Elderly, based on methodology previously pilot tested by AoA. The evaluation study will attempt to measure the impact of the program in terms of its affect on the health status, nutritional

status, isolation, life satisfaction, longevity, and institutionalization of the participants.

(2) Based upon in-house research and information collected by the National Bureau of Standards, AoA has been developing a methodology for the evaluation of the organizational effects of Area Agencies on Aging.

(3) Sent out for comment by selected regional, State and Area Agency personnel the Older Americans Status and Needs Assessment Survey for use by State and Area Agencies. The package will include a utilization manual with ideas for use of the data collected for public relations, legislative relations, planning, evaluation, and coordination and instructions for performing a survey.

(4) Work began, under contract, on the second part of the AoA Data Base to collect data on the minority elderly and services for older persons. The first portion of the AoA Data Base contract has already been completed. This includes statistical data on two of AoA's target groups, the low-income elderly and the impaired, noninstitutionalized elderly, as well as a data organization and Termatrex retrieval system. During 1975 an AoA contractor will proceed on the development of a thesaurus of terms covering the field of gerontology, by which all data base materials will be indexed. This thesaurus will be of use to all professionals in the field of gerontology. Further information on the Data Base is contained in Section G.

(5) Funded a project with the Census Use Study Group, Bureau of the Census, to develop a social statistics system for use by State and Area Agencies on Aging. It utilizes existing data from various sources, organizes the data and allows analysis of the information in order to determine the status and needs of the elderly. A prototype system is being developed for Nebraska. Complete instructions will be provided to allow duplication of the prototype system. A report for use by Area Agencies will be distributed sometime in 1975.

Other evaluation studies in progress are listed below.

(1) *Secondary Data Manual:* A manual outlining the possible sources of secondary data, such as census reports, for use in planning by State and Area Agencies was developed and will be distributed shortly.

(2) *Nutrition Outreach Evaluation:* This evaluation is measuring the effectiveness of the nutrition projects in reaching and serving those most in need including the minority, impaired and isolated elderly.

(3) *Strategy Evaluation for the National Clearinghouse on Aging:* This project will produce a strategy for establishing the National Clearinghouse. It will survey potential users and sources of information as a basis of the strategy.

(4) *R&D Utilization Evaluation:* This project is collecting information on highly utilized and poorly utilized R&D projects in an attempt to determine the internal and external variables which have affected the utilization of the results. Both project staffs and potential users are being interviewed.

(5) *Evaluation and Monitoring Tools for Area Agencies on Aging:* Three self-evaluation and monitoring tools have been developed and are being tested by Area Agencies on Aging. The tools deal with the following areas: (a) Self-assessment of basic functions and preparation for the State assessments; (b) evaluation of existing service providers' capacity; (c) evaluation and monitoring of service providers with whom the area agencies have agreements or contracts; and each of these tools will be pretested in five Area Agencies on Aging in order to determine its applicability and ease of performance. State Agency and Regional Office staffs will also be trained in their use.

(6) *State Agency Evaluation:* This project is using the structured case study approach to evaluating the effectiveness of State Agencies on Aging in terms of their planning, coordination, evaluation, grant administration, advocacy and technical assistance functions. Fifteen State Agencies will be studied and both qualitative and quantitative information will be collected and analyzed. In fiscal year 1977–fiscal year 1978 these States will be revisited for follow-up evaluations.

(7) *Evaluation and Monitoring Tools for the Nutrition Projects:* This project will produce several tools which may be used by nutrition project directors including: combined guide for a site assessment and preparation for State assessments, a former participant questionnaire, a home delivered meals assessment guide, a food service contract monitoring tool, and a community food preparation costs comparison tool.

(8) *Systematic Review of Area Agencies on Aging:* This systematic review of Area Agencies on Aging is a collection and analysis of data on the area agencies. Data relevant to agency type, funding level, staff size, planning and service area

demographic characteristics, etc. has been collected from Regional Offices and State Agencies on Aging. The data is being organized and analyzed in an attempt to identify the major characteristics of the Area Agencies and, as appropriate, to systematically classify the agencies under general types.

(9) *Evaluation of Aging Magazine:* An in-house evaluation is being conducted to assess Aging, a magazine published by AoA's National Clearinghouse on Aging.

(10) *Evaluation of Alternatives to Institutional Care (co-sponsored With SRS):* Work is underway to develop a study methodology through the use of sample surveys to determine costs and impact of various forms of long-term care in both community and institutional settings. The methodological approach is being developed as part of the Older Americans Resources and Services (OARS) study at Duke University, N.C. An actual study will probably be funded in fiscal year 1976.

G. NATIONAL CLEARINGHOUSE ON AGING

In response to the 1973 Amendments to the Older Americans Act, the Administration on Aging initiated the creation of a National Clearinghouse on Aging as authorized by Title II of the Act. The Clearinghouse is charged with: (a) collecting, analyzing, and disseminating information about older people and their needs; (b) providing information to agencies and organizations with respect to programs for older persons; (c) encouraging the establishment of State and area information centers and referral services; (d) carrying out a program of consumer education for older people; and (e) stimulating other agencies to prepare and disseminate information for the field of aging.

Four distinct but interrelated organizational units comprise this new AoA element: Data Analysis and Dissemination, Information and Referral Policy, Public Information, and Public Inquiries and Publications Distribution.

All activities carried out under the Clearinghouse are supported through the regular use of S&E funds available to the Administration on Aging.

AoA needs a wide spectrum of information in order to serve effectively as advocate and program facilitator toward realization of the national goals for older persons, and to meet its own program objectives. The range of information needs includes: general information about the problems and conditions of the elderly necessary to raise the level of awareness, concern, and sensitivity of the public-at-large to the situation of the aged and aging; information intended for older persons to increase their awareness and familiarity with social and health services available for their use; information regarding the results of research in the field of aging for the use of professional practitioners; information on the planning, programming and administration of services for the use of public and private agencies; comparative statistics and related data on the aged and aging to assist decision-makers at all levels in policy formulation, goal specification and resource allocation.

1. *Data Analysis and Dissemination*

In 1974 AoA continued to provide a variety of statistical information to planners, program administrators, researchers, and others within governmental agencies at all levels and to personnel of non-Government organizations. In addition, initial steps were taken to expand the existing collection of data and to equip a data library storage and retrieval system.

(*a*) *Development of the Data Base.*—Contracts were awarded through the use of Evaluation funds to initiate the Data Base. The three awards are cited in Section F of this report. An essential component in the development of the National Clearinghouse, the Data Base will contain a store of materials on the characteristics, circumstances and needs of older persons. In 1974 the focus has been on the collection and structuring of data relative to the low-income and the impaired non-institutionalized elderly. However, the collection is now being expanded to cover the entire older population, with emphasis on racial and ethnic minority groups.

A thesaurus of terms with inputs from professionals and practitioners in the field of aging is being developed for use by persons interested in aging. The thesaurus will be linked to the Data Base. Plans for the development of a dissemination system are being implemented in 1975.

(*b*) *Provision of Statistical Data.*—During 1974, several publications were completed. The *Facts and Figures on Older Americans* series was augmented by the issuance of—

No. 9. *The Older American Indian Population: Geographic Distribution*, 1970

No. 10. *Cumulative Index to Facts and Figures on Older Americans Number 1 through 9*, September, 1974

No. 11. *Income and Poverty in 1973.*

Two new items were added to the statistical series. These included: No. 28 *BLS Retired Couple Budget*, (Supplement #4); No. 29 *Federal SSI and Federally Administered State Supplementation for January 1974, and OAA in October 1973.*

(c) *State Data Books.*—Maintenance of the *State Data Books*, previously supplied to State Agencies on Aging was continued. New data, supplied from a variety of sources, were used to prepare replacement pages which updated a good deal of the State and county statistical information provided in earlier issuances. Additional resource information, originating from other Federal agencies and from private organizations was provided to the State and Area Agencies on Aging.

(d) *Response to Specific Requests.*—AoA responded to numerous requests for demographic, financial, and other data about the older population. Requests came from public agencies at Federal, State, and local levels and from nonprofit and profit-motivated organizations. Data were sought for purposes of research, planning, program administration, and education. Several requests came from the Senate Special Committee on Aging, the House Ways and Means Committee, and other legislative committees.

(e) *Inter-Agency Task Force.*—Preparatory work to the establishment of a Federal Statistical Task Force on the Elderly within the Interdepartmental Working Group on Aging has begun. This task force is scheduled to have its first meeting in early 1975 and will have as one of its goals an inventory of all Federal statistical data relating to the older population.

2. *Public Information*

(a) *Older Americans Month.*—A total of 75,000 copies of the President's Proclamation were distributed widely early in May, along with a folder entitled "Toward a Declaration of Rights and Obligations of Older Americans." The Proclamation called for a revision of the Senior Citizens Charter which had been developed during the 1961 White House Conference on Aging and which listed rights and obligations of older people. It suggested that groups at the community level reconsider this list and develop a new Declaration that can be proclaimed in 1975 and "become a rallying point for our Nation during the Bicentennial year of 1976." The folder repeated this suggestion and included a copy of the original Charter.

During the month, a TV public service announcement on the rights and obligations of older Americans was distributed to commercial television stations and State Agencies on Aging. In States requesting it, the tag line for responses to the spots gave the State agency address. More than 250 television stations responded to a questionnaire card distributed with the spot, indicating that they would give it air time for varying periods, some for as long as a year. Most of the State agencies are offering their spots to cable or public television stations in their States.

(b) *TV Series on Aging.*—A 10-part television series on aging was produced by AoA in association with WRC–TV, Washington, D.C., for showing on NBC-owned stations. The ten 30-minute programs are currently being aired in Washington, D.C., Cleveland, New York City, Los Angeles, and Chicago.

The series examines attitudes toward aging and problems faced by older Americans, and indicates services designed to help older people live more independent and rewarding lives. It is moderated by Bertha S. Adkins, Chairman of the Federal Council on the Aging and features guests from Congress, Federal, State, and local agencies on aging, as well as representatives from national organizations, universities, and non-profit agencies concerned with older people.

(c) *State Communications Conference.*—In November, a pilot communications conference was held in Columbus, Ohio, sponsored by the Administration on Aging, the Ohio Commission on Aging, and the Academy for Contemporary Problems. The purpose of the conference was to stress the need for coordinated planning and action among government and non-government agencies that serve older people and to outline ways to improve communications among these units.

(d) *Major Publications.*—Eight issues of the AoA magazine *Aging* were published in 1974. In a new departure, *Aging* published major signed articles on three topics of national interest: legal advocacy for the low-income elderly, operation of the SSI program, and crimes against older persons.

A Spanish translation of *To Find the Way to Services in Your Community*, entitled *Para Encontrar El Camino A Los Servicios en Su Comunidad*, was printed and distributed through State Agencies on Aging and on mailing lists of the President's Committee on Opportunities for the Spanish Speaking.

The *Guide to Effective Project Operations: The Nutrition Program for the Elderly* was also translated into Spanish and distributed to those States requesting it for the use of project personnel.

A booklet called *Older Americans are a National Resource* and a poster with the same title were printed early in the spring of 1974. The booklet describes the programs of three Federal agencies—the Administration on Aging, ACTION, and the Department of Labor—which provide opportunities for older persons to help their communities.

In addition to fact sheets and press releases, other publications produced during the year included: Three publications prepared by nutrition research and demonstration projects funded by AoA: *Packaging for Home Delivered Meals, A Selected Annotated Bibliography: Nutrition and Aging*, and *Home Delivered Meals: A Selected Annotated Bibliography.*

Older Americans and Community Colleges: An Overview, a directory of community colleges with programs in the field of aging, prepared by the American Association of Community and Junior Colleges as part of a training project funded by AoA.

A number of other publications have been prepared and are now at press, including:

To Find the Way to Opportunities and Services for Older Americans, a revision of the booklet *To Find the Way to Services in your Community.*

The Older Americans Act of 1965, as Amended.

Transportation for the Elderly: The State of the Art, the report to Congress on transportation required by Title IV, Section 412(a) of the 1973 Amendments to the Older Americans Act.

I and R Program Configuration: A Guide for Statewide Planning, the report of a study funded by the South Carolina Commission on Aging.

Home for the Aged: Supervision and Standards, a translation of a German study of homes for the aged in several European countries.

Publication Information Guide for Area Agencies on Aging, a report with suggestions for effective ways of contacting the media, preparing press releases and public service announcements, arranging for public hearings on annual plans, and other related activities.

3. *Information and Referral*

A new requirement set forth in the Older Americans Act Amendments of 1973 is that State and Area Agencies on Aging must provide for all older people to have reasonably convenient access to information and referral services which will help to link them with opportunities, resources, and services that enable them to meet their needs and enhance the meaning of their later years. Assisting State and Area Agencies in launching or improving existing information and referral services has become a major AoA activity. The primary responsibility for developing information and referral data and policy and procedures is lodged in the National Clearinghouse on Aging which works closely with the Office of State and Community Programs.

(a) *Technical Assistance and Guidelines to State and Area Agencies on Aging.*—Agencies providing information or information and referral (I&R) services have been increasing in recent years. Many State and Area Agencies on Aging took steps during 1974 to extend these services to older people. Simultaneously, the Administration on Aging began to accumulate information about the operation and delivery of information and referral services to share with State and Area Agencies. Several manuals describing procedures for establishing and conducting I&R services were distributed to all State Agencies on Aging.

Regulations established pursuant to the 1973 Amendments to the Older Americans Act require that information and referral services become available to all older people by the end of fiscal year 1975. In order to assist State and Area Agencies in identifying existing services of information and referral and fostering the establishment of such sources where none exist, the Administration on Aging issued a program instruction specifying minimum components of I&R services to be put into place by June 30, 1975, and an information memorandum identifying suggested goals toward which State and Area Agencies on Aging should work in the development of these services.

Research and demonstration projects supported by AoA and other agencies, and operational experience in this area have combined to bring about gradual improvements in the nature and quality of information and referral services. A number of national voluntary organizations have formulated standards and recommended them for adoption by the I&R field. Utilizing this material, AoA in collaboration with regional office, State Agency, and Area Agency personnel, developed a reference guide for the use of State and Area Agencies on Aging which identifies the components of a comprehensive information and referral service.

AoA has also provided for training of selected personnel and additional technical assistance to State and Area Agencies in planning and developing I&R services which meet AoA requirements. Three consecutive four day training sessions were held in Philadelphia, Chicago and San Francisco.

(b) *Interagency Cooperation.*—The Older Americans Act mandate in regard to information and referral services makes it essential that existing I&R resources are utilized maximally. Toward this end, AoA has been involved in concentrated efforts to produce both intradepartmental and interdepartmental cooperation in this program area.

Through an intradepartmental agreement, DHEW's resources for older persons will be coordinated by the establishment and tracking of joint information and referral service objectives among the Administration on Aging, the Social Security Administration, and the Social and Rehabilitation Service.

Similarly, through an interdepartmental agreement AoA has enlisted the support of fifteen Federal agencies to work in concert toward making I&R activities at the State and local levels more responsive to the needs of older people. These Federal agencies have also agreed to monitor and evaluate their progress toward this objective.

In addition, the 25 Federal Executive Boards (FEB's), composed of heads of Federal agencies, took as their major project in FY 1975 the improvement and coordination of I&R services and government information services in the areas they serve. FEB personnel, working closely with State and Area Agencies on Aging, are expected to have a major impact on the improvement of information and referral services for the 50 plus percent of the older population that resides within the FEB areas.

(c) *Grants and Contracts.*—To obtain information pertinent to the I&R field in general, AoA made a number of contracts and grants during 1974 which will document and assess I&R systems, investigate the cost effectiveness of a sample of I&R services, and compare the effectiveness of I&R's serving older people exclusively with that of I&R's serving people of all ages. Those studies are cited in Section D of this report.

4. *Public Inquiries and Publications Distribution*

During 1974 the Public Inquiries and Publications Distribution unit prepared 1,600 letters in response to a broad range of inquiries concerning needs of older persons in such areas as transportation, social services, housing, health care, senior centers, income-security, nutrition, legal services, employment, volunteer opportunities, and consumer protection. A number of inquiries and comments were received concerning the affects on older persons of current economic and energy problems. Many of these inquiries are forwarded by Congressional offices, the White House and Federal Agencies, as well as private organizations, older people, and persons working in the field of aging.

In addition, over 3,000 telephone calls were responded to and a number of visitors were given assistance and information.

During the year AoA distributed 485,000 copies of publications addressed to older people and to personnel of agencies serving the older population. Many of these go out with letters in response to inquiries; the majority are distributed in response to direct requests from individuals or from organizations for distribution at meetings and conferences. Bulk orders are distributed by the Office of Human Development's Publications Distribution Center. Most of AoA's publications are also sold by the Superintendent of Documents.

II. SPECIAL PROJECTS

1. *AoA Role in Disaster Planning*

Like other government and private agencies, the Administration on Aging moved quickly to aid elderly victims of tornadoes which made a destructive sweep across eleven States in Regions IV and V on April 3, 1974.

The Administration on Aging Central and Regional Office staffs were immediately ordered to work with State and Area Agencies on Aging in the affected areas. They helped put elderly disaster victims in touch with emergency assistance provided through such groups as the American Red Cross, Salvation Army, and the Federal Disaster Assistance Administration (FDAA).

AoA staff worked with State and area officials to determine the extent of losses suffered by the elderly, the extent of unmet needs, and the resources available to disaster victims. The Area Agencies on Aging followed up with the elderly disaster victims to: (1) inform them of the types of assistance available from disaster relief programs, (2) ensure that they were linked up with emergency services, (3) assist them in dealing with the processing of claims, and (4) work with the service providers to inform them of the special needs of the elderly as well as any specific eligibility criteria which might have precluded the participation of persons aged 60 and over in disaster relief programs.

A variety of services were extended to elderly victims. These included medical services funds to replace such lost items as eyeglasses and dentures; meals from AoA's Older Americans Act Title VII nutrition program; use of ACTION-RSVP volunteers; senior aides from a Department of Labor program who assisted in cleanup operations and minor home repairs; relief funds from the Office of Economic Opportunity; and a State optometrist society which provided eyeglasses.

An example of State level response occurred in Indiana where the State Commission on Aging and Aged, with the backing of the Governor, embarked on Project Transition, a follow-up operation to make sure all disaster related resources were made available to elderly victims.

On the national level, AoA worked closely with the American Association of Retired Persons-National Retired Teachers Association, whose mission was to focus the attention of national voluntary organizations and to stimulate action when necessary to aid the elderly.

Where necessary, AoA made available funds under its Older Americans Act Title III Model Project authority to aid local relief operations.

As a result of close monitoring of the Model Project grants and frequent site visits, the Administration on Aging gained considerable knowledge of the approach State and Area Agencies on Aging should take in meeting the special needs of elderly disaster victims. Utilizing this knowledge, the Administration on Aging began working closely with the Department's Civil Defense Coordinator and the Federal Disaster Assistance Administration regarding these special needs. Subsequently, the pamphlet *HEW Disaster Assistance Programs* was revised and included information developed by AoA on assistance for older people. In addition, AoA submitted to the Federal Disaster Assistance Administration a set of suggested areas of concern regarding older people.

In November the Federal Disaster Assistance Administration included AoA's set of suggestions in its program guidance for the States and in its own review and evaluation of disaster programs and plans developed under the Disaster Relief Act of 1974. Accordingly, the Administration on Aging instructed the State Agencies on Aging to initiate efforts which will assure that State disaster preparedness plans include provision for older disaster victims. Other AoA activities in regard to disaster assistance for older persons included conferences with the American Red Cross, AoA Regional Offices and State Agencies on Aging.

2. *SSI-Alert Outreach Activities*

Beginning with a press conference held by the Secretary of the Department of Health, Education and Welfare on November 29, 1973, Phase I of SSI-Alert was launched as a joint effort in which two DHEW agencies, the Social Security Administration and the Administration on Aging, joined with a national consortium of eight voluntary organizations to:

(a) Seek to enlist the assistance of all the public media in explaining who is eligible for the Supplemental Security Income Program and how individuals can establish this eligibility;

(b) Utilize personnel in the field offices of certain departments and agencies of the Federal Government to help identify persons who might be eligible for the program;

(c) Provide a volunteer-supported local procedure for receiving, listing and transmitting the names and addresses of potential SSI eligibles to the Social Security district offices;

(d) Provide a focal point for the recruitment, training and utilization of volunteers to seek and explain to individuals the nature of the program and the steps to be taken to determine eligibility; and

(e) Facilitate the determination of eligibility for those potential eligibles who desire to become a part of the new program.

It was expected that as a result of Project SSI-Alert, many thousands of older disabled and blind persons eligible to participate in the benefits of the SSI program would, in fact, receive these benefits. SSI-Alert outreach was especially addressed to those hard-to-reach persons, including minority older persons, who are often not reached by assistance programs. Project SSI-Alert was designed to effectively insure that the goals established by the Congress in enacting the Supplemental Security Income program would be met with regard to potentially eligible older persons, who could be reached by volunteers.

At the request of the Administration on Aging, the American National Red Cross facilitated the participation of local Red Cross chapters to become the lead agencies in working with the local consortia in the selection of a project director, in the recruitment and training of volunteers and in the development and conduct of the program. Local Red Cross chapters became the lead agencies in 412 out of the 631 Social Security district office areas. Area Agencies on Aging became the lead agencies in 49 districts, Community Action Agencies in 58 districts, and other community organizations in 112 districts.

State agencies on aging were designated as the State-wide lead agency for their respective States and were given FY 1973 and FY 1974 Model Project grants for SSI-Alert implementation. The State agencies were:

(a) Authorized to recruit a staff person to provide over-all leadership.

(b) Authorized to approve budgets submitted by the lead agencies within the Social Security districts in their States up to the total amount set aside for each State, and

(c) Charged with the responsibility of selecting a lead agency for the Social Security districts within their States where the local Red Cross chapter decided not to participate.

During the approximately seven months that SSI-Alert has been in operation, tens of thousands of volunteers have participated with the largest number, namely, 55,775, being recorded in the first week of April.

Many methods have been employed by the consortia and the lead agencies to call the Supplemental Security Income program to the attention of potential eligibles—methods which have called for ingenuity, imagination and resourcefulness. There has been extensive use of all of the mass media, wide distribution of flyers and telephone and mail contact.

It is impossible to identify the number of new SSI applications that are attributable solely to Project SSI-Alert. It is clear, however, that the total effort has produced results that have improved life for well over a million persons.

On May 4, 1974, the Administration on Aging and the Social Security Administration issued memoranda to the SSI-Alert projects and Social Security district offices describing a renewed thrust, Phase II, to reach additional potentially eligible SSI beneficiaries. Up to one half the amount of Model Project funds granted per district office in the State for Phase I were granted to the States for Phase II implementation.

Phase II of SSI-Alert involves a mailing to the individuals included in the Social Security Master Beneficiary Record (MBR) leads list with follow-up done by SSI-Alert volunteers or Social Security personnel with those individuals who express an interest in applying for Supplemental Security Income benefits. Specific guidelines for Phase II implementation were issued on June 12 and July 12, with an anticipated completion date of November, 1974.

Over three-quarters of the States have continued some type of SSI-Alert activities into 1975. There was a realization that the outreach and follow-up efforts provided by the volunteer network in SSI-Alert offered a great potential for resolving a number of problems for older persons. Through coordination between the State and Area Agencies and the Social Security District offices in utilizing their information and referral services, the SSI-Alert is continuing as an ongoing part of outreach activities.

REHABILITATION SERVICES ADMINISTRATION

The major goal of the Rehabilitation Services Administration's program for the Aging is to rehabilitate as many older handicapped individuals as possible into gainful employment through activities of the State-Federal rehabilitation program administered by the agency.

The Rehabilitation Services Administration endeavors to assist each individual to reach his most adequate functioning level and highest potential. This is accomplished through a diagnosis of his condition followed by various services designed to overcome his specific handicap. Throughout the process, the emphasis is on helping the individual to help himself. These services include: evaluation and medical diagnosis to determine the nature and extent of the disability to ascertain capacity for work; counseling to help in developing a good vocational plan; medical care to reduce or remove the disability; vocational training and placement into employment; and follow-up to ensure satisfactory placement.

Progress in Rehabilitation of the Aging.—It is estimated that there are over 4 million people 45 years of age and older eligible for, and in need of, rehabilitation services, of whom nearly 1 million are aged 65 and beyond.

In an effort to alleviate this, State rehabilitation agencies have been intensifying their efforts to serve the aged handicapped and a steady increase in the number of these individuals has resulted. For example in fiscal year 1959, a total of 80,739 disabled persons were rehabilitated into employment, of whom 24,275 were aged 45 and over and 1,432 were aged 65 and over. In fiscal year 1973, a total of 360,726 disabled persons were rehabilitated into employment 84,400 of whom were aged 45 and beyond and 5,400 were aged 65 and beyond.

Training.—Short-term Training courses have served to focus on problems faced by older handicapped persons and stimulate interest on the part of professional rehabilitation staff, and staff from health, welfare, and other agencies who may attend, in developing methods and techniques to cope with these problems. A recent course sponsored by the Rehabilitation Services Administration and San Diego State College focused on vocational rehabilitation and the older handicapped worker. Staff from States in Region IX attended this meeting together with staff from appropriate public and private agencies in the San Diego area

In 1971, a Short-term Training course was conducted to prepare recommendations to be presented to the 1971 White House Conference on Aging.

Two Regional Short-term Training Courses were conducted in 1973. One was held in Region IV in Clearwater, Florida and the other in Region II in New York City. Each focused on recommendations on rehabilitation voted upon by delegates to the White House Conference on Aging. RSA staff from States in these Regions attended as well as staff from other appropriate public and private agencies in the Regions.

Special Activities in the State Agencies.—State rehabilitation agencies have utilized expansion grants and Basic Support resources to expand their services to the aging disabled. For example, the Iowa rehabilitation agency has worked cooperatively with the Easter Seal Society in that State on a project for the home bound which serves a large number of older disabled people. Also, the Ohio rehabilitation agency has participated in a public housing project designed for the handicapped and senior citizens.

Currently, three expansion grants are in operation focused on rehabilitation of the aged disabled on, or near, the poverty level into employment. Public Welfare recipients are also included in this grouping. These projects are located in New York, Illinois and Massachusetts.

Social Security Disability and Supplemental Security Income Applicants.—The Rehabilitation Services Administration coordinates with Social Security Administration in utilizing the Social Security disability and Supplemental Security applicant loads as important referral sources of older disabled persons for State vocational rehabilitation services.

Future Plans.—The Rehabilitation Services Administration cooperates with the Administration on Aging in various activities such as Senior Citizens Month, White House Conference on Aging and other special projects and will continue to do so.

A joint agreement between the Administration on Aging and the Rehabilitation Services Administration is being prepared which will bring about improved program activity between the two agencies.

STATE REHABILITATION AGENCIES: REHABILITATED PERSONS 45 YR OF AGE AND OVER AND 65 YR OF AGE AND OVER AT ACCEPTANCE (FISCAL YEARS 1973–75)

	All rehabilitants	45 yr of age and over	65 yr of age and over
Fiscal year:			
1973	360,726	74,164	5,069
1974	361,138	[1] 72,000	[1] 5,500
1975 [1]	[1] 360,000	[1] 72,000	[1] 5,500

[1] Estimate.

THE OFFICE OF CONSUMER AFFAIRS

The Office of Consumer Affairs (OCA) assures that the consumer's interest is reflected in Federal policies and programs, cooperates with State agencies and voluntary organizations in advancing the interests of consumers, promotes improved consumer education, recommends legislation of benefit to consumers, encourages productive dialogue and interaction between industry, government and the consumer, and provides continuing policy guidance to the Consumer Product Information Coordinating Center.

Its major activities, however, fall within four primary categories: (1) consumer advocacy, (2) consumer education, (3) consumer redress, and (4) planning and analysis. While these activities in general are initiated on behalf of all consumers, it should be noted that the elderly consumer shares fully in the benefits of OCA programs.

Highlighted below are major activities in each of these categories with special emphasis on those having the greatest impact on older Americans.

1. CONSUMER ADVOCACY

INTERAGENCY COMMITTEES

The Office of Consumer Affairs is a member of the Domestic Council Committee on Aging which has been charged with responsibility for developing coordinating and presenting both short-term and long-range policy issues in this area. Through a task force of the Committee's Interdepartmental Working Group, OCA has participated in the development and signing of an interdepartmental working agreement on information and referral services for the elderly.

The inflationary impact of the energy crisis on the elderly in particular has been consistently taken into consideration in OCA's ongoing active participation in such top level interagency task forces as the Energy Resources Council, (and its predecessor, the Committee on Energy), the National Power Survey, and the Federal Power Commission's Task Force on Natural Gas Curtailment.

At OCA's request the Federal Power Commission is systematically collecting data for the first time on the impact of natural gas shortages on the elderly and on the institutions affecting them most significantly such as hospitals.

Additionally, OCA co-sponsored public hearings and provided staff analyses through its membership on the President's Council on Wage and Price Stability. During November 1974 public hearings were conducted on the repricing of shelf inventories and on the rapid increase in sugar prices which were directly related to the current problems borne by the elderly consumer and specifically those on low, fixed incomes.

LEGISLATIVE COMMENTS AND CONGRESSIONAL SUPPORT

OCA's Office of Economic Policy and Planning provided data to the Joint Economic Committee specifically assessing the impact of inflation on the elderly, especially the lower-income. These data reflected the inflationary impact on the elderly of such specifics as food price increases and the impact of significant cost increases in local/public transportation on which the elderly are dependent. Such contributions by OCA to Congressional study and ultimate action on the problems of the elderly consumer are particularly relevant.

OCA has continued to support legislation pending before Congress in behalf of the consumer as well as proposing and commenting on proposed changes in Federal regulations. For example, OCA submitted comments to the Civil Aeronautics Board urging the development of charter rules to facilitate price competition. Clearly, older citizens are prominent among the groups of tourists adversely affected by more restrictive charter rules.

At the end of 1974, OCA had under active review a proposed regulation which would have a special impact on the elderly. This is the proposed change by the Social Rehabilitation Service in the regulations implementing the provision of the Social Security Act mandating upper limits of reimbursement for prescribed drugs in the medical assistance program administered under Title XIX, Social Security Act. Further, the Office of Consumer Affairs will continue to seek the lifting of prohibitions on the posting of prescription drug prices and eyeglass prices. This would particularly assist elderly consumers to stretch their medical dollars by allowing them to comparison shop.

VOLUNTARY CONSUMER ORGANIZATIONS

The Office of Consumer Affairs has continued to maintain close liaison with national associations having special interests in the problems of the elderly and has also continually worked to assure that spokesmen for the elderly be included in consultations seeking consumer leader advice on national policy issues. In this connection, OCA assured that representatives of the elderly participated in the Administration's pre-summit and summit meetings on the economy and the energy policy seminars on consumer concerns sponsored by the Energy Resources Council.

STATE AND LOCAL CONSUMER PROGRAMS

The Office of Consumer Affairs in 1974 through day-to-day liaison continued to encourage and assist state and local governments in their responsiveness to consumer problems, including those of the elderly. By December 31, 1974, these totaled 127 state consumer offices, 96 county offices, and 56 city consumer offices, and a growing number of these offices now have, or are considering, special information and education programs for the aging and/or concentrated enforcement efforts against frauds and deceptive practices which are directed toward the elderly.

For the past three years, the Office of Consumer Affairs has compiled and distributed *State Consumer Action*, which provides summaries of consumer laws and administrative programs adopted during the year by state, county, and city governments. The 1974 edition, now under preparation, will have a special section devoted to programs for the elderly consumer.

OCA's *Directory of State, County, and City Government Consumer Offices* includes a listing of toll-free telephone lines in operation to help facilitate consumer contacts with those offices. This listing was included in order that the Directory could be of special assistance to the homebound and/or handicapped consumer. Both *State Consumer Action* and the *Directory* are available to the general public through the Government Printing Office.

2. CONSUMER EDUCATION

PUEBLO INDIAN CONSUMER EDUCATION AND ADVOCACY PROGRAM

OCA developed, coordinates, promotes and monitors an interagency demonstration project operated by an all-Indian staff from the All Indian Pueblo Council. This program has trained Indian consumer officers from the 19 Pueblos who, backed by a small central staff in Albuquerque, work out of individual offices on their Pueblos. They conduct consumer education classes which many elderly Indians actively attend, and because the consumer officers all speak their native Pueblo language, they are able to communicate with the elderly citizens. In fact, the link between the young consumer officers and the elderly Indians has generally been a very beneficial and mutually supportive one.

VOLUNTARY BUSINESS EFFORTS

OCA has been heavily involved in stimulating consumer education efforts by business including unit pricing explanations, life insurance cost comparisons, information on the true costs of appliances including energy efficiency and consumption, speedy transition to nutritional labeling, and consumer education in the banking industry—all of which redounds to the benefit of senior citizens as well as the general population.

FEDERAL EXECUTIVE BOARDS

During 1974, OCA continued to provide guidance and technical assistance to the Federal Executive Boards in their consumer education and information efforts. At the end of fiscal year 1974, 17 of the 25 FEBs were actively engaged in providing consumer services to senior citizens and/or to representatives of senior citizens organizations. It is conservatively estimated that over 25,000 older Americans were the recipients of consumer education, information and referral services as a result of FEB activities during the year.

OCA has encouraged the FEB's to continue these activities during fiscal year 1975, tying in wherever possible to the Information and Referral services program of the Administration on Aging.

CONSUMER NEWS

In addition to carrying articles in every issue of general interest to older Americans—as to all consumers—*Consumer News* focuses on specific news of Federal activities of special concern to the elderly.

A few examples: nutrition programs for the elderly; transportation programs for the elderly; prescription drugs; hearing aids; condominiums; high blood pressure; funeral homes; and IRS tax publication for older Americans.

In addition, *Consumer Register*, which carries summaries of regulations of Federal agencies, includes material of special interest to older Americans, such as those dealing with Social Security; Federal Energy Administration's Special Impact Office; nursing homes; and prescription drugs.

"DEAR CONSUMER" AND "HELP"

"Dear Consumer" columns, which are provided as a public service to more than 7,000 weekly newspapers, occasionally deal with topics that primarily concern older Americans. "Nursing Homes: Care and Rights" and "Credit for Retirees?" were two such columns. The four-minute Public Service Radio program, "HELP," which is sent to over 450 radio stations throughout the U.S., frequently has programs designed for the elderly. Recent broadcasts have included such topics as "The Rights of the Widow," and "AoA Programs."

CONSUMER INFORMATION INDEX

OCA provides policy coordination to the Consumer Information Center which has the responsibility to identify areas of needed consumer information, encourage Federal agencies having the appropriate expertise to publish such information in a manner useful to the public, make the public aware that the information exists and finally distribute millions of copies of such information to the requesting members of the public.

At the suggestion of OCA, the 1975 Spring edition of the *Index* will carry a special section for older Americans, listing selected publications of interest to senior citizens.

"AN APPROACH TO CONSUMER EDUCATION FOR ADULTS"

The purpose of the adult guidelines is to assist educators to establish and conduct consumer education programs for persons beyond the high school level. In a section on "Consumers with Special Needs," the adult guidelines address particular problems of the elderly, especially those who live alone and who must depend on fixed incomes.

3. Consumer Redress

INDIVIDUAL COMPLAINT HANDLING

OCA is the central Federal facility for handling individual consumer complaints. Between 2,000 and 3,000 such complaints are handled monthly. About 25 percent are referrals from the President, members of Congress and other Federal agencies. The balance are direct communications from consumers. In each instance the complaint is carefully analyzed and the responsible agency, firm or trade association is asked to evaluate the complaint and to institute or recommend corrective actions. Personalized attention in the form of a telephone call and other follow-up is not uncommon when a complaint is received from a senior citizen who needs special services.

VOLUNTARY COMPLAINT HANDLING BY THE PRIVATE SECTOR

In its continuing effort to encourage private industry to voluntarily develop self-regulatory programs and competitive actions aimed toward resolving problems common to large numbers of consumers, including the elderly, the Office of Consumer Affairs has sought to establish consumer complaint-handling mechanisms within specific industries, such as major appliances (Major Appliance Consumer Action Panel), auto dealers (19 Automotive Consumer Action Programs), and furniture (Furniture Industry Consumer Advisory Panel). As a result of these efforts, commitments have been received from the Southern Furniture Manufacturers Association, the sponsor of FICAP, and from the National Tire Dealers and Retreaders Association to establish consumer complaint "appeal" mechanisms within its industry.

4. Planning and Analysis

During the past year the Office of Consumer Affairs instituted a separate economic analysis and planning unit with responsibilities in three major areas: (1) analytic support for specific programs, proposals, and policy advisory activity; (2) systematic development of economic planning data in the consumer area aimed at identifying programs having maximum impact in achieving defined consumer objectives; and (3) evaluation of programs and activities in terms of post-performance measurement of consumer impact.

The planning and analysis unit has provided and continues to provide analytic support in several areas. Among these are energy, inflation, productivity, credit, supply allocation, and food price problems—all of which greatly affect the elderly consumer.

In the year ahead, OCA will be promoting the consumer's understanding of the lifetime or true costs of appliance ownership by pressing for government and industry action; developing a publication that will provide consumers with evaluative information on local consumer services, such as nursing homes, health insurance, banking, credit, and auto service; encouraging the supermarket industry to eliminate sources of consumer irritation in the marketplace, such as upward repricing of shelf items, elimination of price markings on individual items when automated check-out systems (UPC) are installed by major food chains, and the improved quality and availability of unit pricing and open-dating programs; creating complaint-handling mechanisms within the household moving and hearing aid industries; and developing a nationwide network of the AUTOCAPS. OCA will also be developing a standard system for gathering consumer complaint data, designed to improve the Federal government's ability to respond to consumer complaints and conducting a nationwide, demographically stratified survey of consumer satisfaction and dissatisfaction with product and service purchases that will give for the first time a complete statistically reliable profile of the consumer problems most significant to the elderly.

SOCIAL SECURITY ADMINISTRATION

The Social Security Administration (SSA) administers the Federal old-age, survivors, disability, and health insurance (OASDHI) program (titles II, VII, XI, XVI, and XVIII of the Social Security Act as amended) and, for a specified period, the black-lung benefit provisions of the Federal Coal Mine Health and Safety Act of 1969. In January 1974 SSA began administering the Federal supplemental security income (SSI) program for the aged, blind, and disabled (title XVI).

Social Security coverage is the Nation's basic method of assuring income to a worker and his family when he retires, becomes disabled, or dies and of assuring hospital and medical benefits to persons aged 65 or over and to certain disabled persons. As of the end of 1974, 120 million workers (including 15 million over age 65 receiving benefits) were insured for retirement and/or survivor benefits; 82 million of these were insured also for disability benefits. Half the persons now being awarded benefits in any given year are under age 65.

1. LEGISLATION

Amendments to the Social Security Act affecting the supplemental security income program, Medicare, and unemployment benefits were enacted in 1974. On July 6, Public Law 93–335 was signed, extending until July 1, 1975, the period in which SSI recipients can participate in the food stamp program in States that had not previously indicated their intention to "cash out"—to replace the stamps with increased cash assistance of equal value. The new law also requires that in the States with cash-out provisions—California, Massachusetts, Nevada, New York, and Wisconsin—the January 1972 bonus value of food stamps must now be included in the income level the States have to maintain under the mandatory supplementary requirements.

On August 7, the President signed Public Law 93–368, which further affects the SSI program. This law calls for cost-of-living increases in SSI payment levels whenever such increases occur in social security cash benefits and sets the criteria for repayment to a State for interim assistance rendered to SSI applicants. Other provisions of the August amendments include a further deferment in beginning reimbursement on a cost basis for teaching physicians' services under Medicare and extension through April 30, 1975, of the liberalized rules for payment of unemployment insurance benefits.

2. BENEFITS AND BENEFICIARIES

At the end of October 1974, 30.6 million people were receiving monthly social security cash benefits. Two-thirds of them (19.3 million) were retired workers and their dependents. The remaining beneficiaries were 3.8 million disabled workers and their dependents, 7.2 million survivors of deceased workers, and 292,000 uninsured persons aged 72 or over.

The monthly rate of benefits for October 1974 was $4.9 billion. Retired workers received an average monthly benefit of $187; disabled workers, $205. For persons coming on the rolls for the first time in that month, the average awards were higher—$193 for retired workers and $218 for disabled workers.

Benefits paid during fiscal year 1974 under the retirement, survivors, and disability provisions of the social security program amounted to over $54 billion. Of that total, retired workers and their dependents received $34.4 billion in monthly benefits; survivors of deceased workers, $12.9 billion; disabled workers and their dependents, $6.2 billion; and special age–72 beneficiaries, $251 million. Lump-sum death payments accounted for $316 million of the total.

For beneficiaries under the black-lung benefits program, the monthly rate of benefits in September 1974 was $67 million; per family the average benefit was almost $224. Over 482,000 persons were receiving monthly benefits—168,000 miners and 314,000 dependents.

3. MEDICARE OPERATIONS

In July 1973, almost 22 million aged and 2 million disabled persons were enrolled for hospital insurance benefits under Medicare; slightly smaller numbers of both groups were enrolled for medical insurance. Under hospital insurance, approved claims for all of fiscal year 1973 totaled 6.9 million. Inpatient hospital claims accounted for almost 90 percent of this total and for more than 97 percent of the $5.5 billion reimbursed under hospital insurance for that fiscal year. The average amount reimbursed per inpatient claim was $877. Hospital benefits are financed from part of the total social security contribution. Persons aged 65 and over who are not eligible for Medicare hospital benefits may voluntarily enroll for them and pay a monthly premium. This premium was $33 in fiscal year 1974,

$36 in fiscal year 1975, and will be increased to $40 beginning July 1, 1975. During fiscal year 1974, intermediaries withdrew $7.8 billion from the hospital insurance trust fund for services under this program.

Under Medicare's supplementary medical insurance program, 56.4 million claims were recorded for fiscal year 1974, 80 percent of which were for physicians' services. Of the $2.6 billion in total reimbursements, 86 percent were made for physicians' services; reimbursements for the latter represented 70 percent of the charges allowed under the program for fiscal year 1974. The medical insurance program is financed by monthly premiums paid by those who elect to enroll for coverage and matched by the Federal Government. In July 1974 the amount was increased from $6.30 to $6.70. During fiscal year 1974, carriers withdrew $2.9 billion from the medical insurance fund for services under the program.

4. Supplemental Security Income

In January 1974 Federal grants to the State-administered programs of old-age assistance (OAA), aid to the blind (AB), and aid to the permanently and totally disabled (APTD) were replaced by the Federal supplemental security income program for the aged, blind, and disabled. The new program, based on need, is financed from Federal general revenues and establishes a Federal income floor as a base. States that paid amounts higher than this Federal floor to recipients under OA, AB, and APTD must supplement the Federal payments to maintain the higher income levels of these recipients through mandatory minimum State supplementation. States can, in addition, supplement Federal payments through optional State supplementation programs. At the end of 1974, all States were providing mandatory supplementation; 33 were providing optional supplementation. States have the choice of administering their own supplemental programs at the State or local level or of having the Social Security Administration administer the programs for them at the Federal level. The 32 States and the District of Columbia that have chosen Federal administration are protected against increases over the 1972 costs for welfare payments to the aged, blind, and disabled because of increases in the numbers of eligible persons. By the end of calendar year 1974, almost $5.3 billion had been paid under the SSI program; federally administered payments made up more than $5.1 billion of this total. In November alone, federally administered benefit payments amounting to more than $454 million were made to 4 million persons—2.3 million aged persons received $210 million in benefits; 1.6 million disabled persons received $234 million; $11 million went to the fewer than 100,000 blind SSI recipients. At the beginning of fiscal year 1975, the monthly benefit for an individual was raised from $140 to $146; for a couple, it was increased from $210 to $219.

SOCIAL AND REHABILITATION SERVICE

1. Research and Evaluation

No SRS programs are targeted on the aged population per se, but elderly persons make up a large percentage of the client population in the Medicaid and Social Services programs, particularly in the long-term care area. The evaluation and research activities of SRS, therefore, consider the aged as a significant subgroup of the client population.

During fiscal year 1974 the evaluation activity most significant for the elderly was a project funded jointly with the Administration on Aging and the Health Resources Administration. This project focuses on de-institutionalization and the question of what is appropriate care for impaired persons.

Fiscal year 1974 emphasis was on development and testing of the methodologies necessary for a nation-wide longitudinal survey, including a functional classification system for adult persons requiring long-term care, a comprehensive set of LTC service packages and settings, and a costing methodology. A major field-test of the functional classification system and survey instrument is to be completed in June 1975, and development of the service package and costing methodologies is continuing. The final stages of development and preparation of the three methodologies for use in a nationwide survey will be funded in fiscal year 1975, and discussions are beginning with other units of the Department to determine more precisely the target population and the best means of obtaining a longitudinal sample representative of the entire LTC universe (both institutionalized and non-institutionalized). The nationwide survey, which will of necessity be a Department-wide effort, will be funded no earlier than fiscal year 1976.

Several other evaluation efforts will provide information about the effects of SRS programs on target population which include the elderly. One such project, funded in fiscal year 1974, is an evaluation of the "spend-down" provision of the Medicaid program which will obtain data on socio-demographic and economic characteristics of persons who entered the Medicaid program through the spend-down mechanism, including the effects of the spend-down on their income and assets, and the health service requirements which caused them to enter the program.

Last year the Office of Research and Demonstration within SRS created a separate and identifiable unit in the Health Services Division to focus on long-term care. Analysis of long-term care financing, developing alternatives to institutionalization, and studying the impact upon health care delivery systems is being emphasized.

Although the long-term care R&D program is primarily concerned with the delivery of health care services to the chronically ill and disabled of all age groups, the elderly comprise the highest proportion of the population in need of these services. During 1974, two major projects exploring the improvement of service delivery for long-term care recipients were initiated. The first project, the Utah Long-Term Care Payments System, is a State-wide experiment designed to link reasonable cost-reimbursement with the quality care within skilled nursing facilities. The $600,000 project is part of the Agency's program preparing for the requirements of section 249 of P.L. 93–603.

The second project is primarily concerned with exploring the viability and cost-effectiveness of delivery services to the chronically ill and disabled in various types of community settings. Promoting community care alternatives to institutionalization for the chronically ill and disabled interested in and able to function outside of institutions can have an important effect upon the lives of the elderly. The project, "The Feasibility and Cost-Effectiveness of Alternative Long-Term Care Settings," a $263,000 study being undertaken by Stanford Research Institute, is investigating long-term care service delivery programs outside of nursing homes, day care centers and long-term hospitals. A companion investigation of day care centers is being undertaken by the Health Resources Administration under section 222(b) of Public Law 92–603. When completed, the SRI project will provide extended systematic information on studies of alternative long-term care settings; provide a number of case studies with guidelines on initiating similar programs useful to innovators developing community care programs; form a base for identifying cost-finding methods for comparing cost in different settings; and provide policy and program change recommendations emerging from the study of the effects of legislative, regulatory, or administrative programs on the feasibility of establishing, and the viability of operating, such programs.

Current plans for research and demonstration projects for 1975 include the initiation and analysis of community-wide coordinated health and social service delivery programs; the analysis of prospects for developing a system of cost classification for long-term care service delivery programs independent of particular settings; and the development of analytical tools for appraising the response of the chronically ill and disabled to alternative possibilities for long-term care services. Total estimated funding for these projects during 1975 is over a half a million dollars.

2. SOCIAL SERVICES PROGRAM

The Community Services Administration, SRS, is the Federal bureau responsible for the Federal grant-in-aid program of social services to aged, blind or disabled SSI recipients which is administered by 49 States and the District of Columbia under title VI of the Social Security Act. Congress appropriated 2.5 billion for the program in FY 1974 for title IV–A (AFDC) and title VI(ABD) services. Of this total of Federal funds, $390 million was spent exclusively on services to aged, blind or disabled. Of that amount, it is estimated that one-half was spent on the services to the aged, alone, since they constitute approximately 50 percent of the caseload served by States. Over-all, as of June 1974, there were 3.43 million SSI recipients. Of this number, the aged constituted 2.02 million individual recipients.

It is estimated that 2,247,000 aged, blind or disabled individuals who were recipients (current, former or potential) of supplemental security income benefits received one or more services in FY 1974. Since aged, blind or disabled SSI recipients are for reporting purposes inseparable, it is not possible to identify here, or in the following charts, an exclusive break-out for the aged, alone.

The following chart provides some indication of State *service priorities* as of June 30, 1974.

Type of service	Number served	Expenditures (millions)	Number of States
1. Health support service	773,000	$85	43
2. Protective services	324,000	73	43
3. Services to drug abusers	212,000	57	37
4. Family planning services	175,000	3.3	42
5. Homemaker or chore services	161,000	68	(1)
6. Services to mentally retarded	138,000	42	34

[1] HM 43—Ch. 38.

The volume of protective and health support services reported is a reflection of the predominate aged characteristics of serious physical and mental impairments coupled with great age. (Average age 65+ in 1970 was 76.4 years.) An *additional* service increment became available to the aged on April 1, 1974 when homemaker service which until that time was an *optional* service with the States became a *mandatory* service, thus ensuring a better in-home community support service for the aged and which helped to reduce unnecessary institutionalization.

With the passage of Public Law 92–603, the income maintenance program for aged, blind or disabled which since the 30's had been administered by States was transferred to the Social Security Administration. States retained the administration of the social services program for aged, blind or disabled. However, this action removed the "one-stop" concept for money and services and created a problem for the aged who needed to make "two stops." They would now look to the SSA District Office for their money payments and to the local department of social services to meet their service needs.

The Secretary of Health, Education, and Welfare took leadership in forging those working relations between the SRS (CSA) and the SSA to ensure information and referral linkages to social service between the SSA District Office and the local departments of social services. Out of this joint SSA/SRS effort at the Federal level there developed initiatives resulting in all but one State having agreements in force (formal or informal) for service linkages to help the aged and other clientele of SSA to access to services.

An interesting development was the establishing, in 11 States, of an outstationed worker from the local department of social service in a District Office of Social Security. This worker facilitated information and referral for service to the local DSS for new SSI applicants and eliminated the necessity for long waiting periods for services on the part of SSI clientele at the local public service agency.

An important by-product of this Secretarial initiative was the focus upon the current limitations in the SSA program because of staff shortages, to make timely referrals to services. States reported limited referrals for service from SSA during the period.

During the period, the Community Services Administration continued to carry out joint planning and actions with other DHEW components and with nongovernmental organizations.

In cooperation with the Department of Transportation, CSA has distributed a report on rural transit operations and management to all States. This report has been helpful to clients in considering and utilizing new methods and opportunities for *transportation*, which is one great need of the elderly. Also CSA on behalf of the Department is working closely with HUD staff to update an agreement whereby public social service agencies may enter into cooperative working agreements with Public Housing authorities to provide social services for the aged living in public housing.

Also, the Community Services Administration during the period has participated in joint planning with the Administration on Aging and the Social Security Administration to develop a working agreement on Information and Referral for use of States. CSA staff have continued to participate in a number of conferences and institutes under the auspices of the National Council on the Aging, the

National Council of Senior Citizens and other groups in the field of aging concerned with the problems of the elderly.

PLANS FOR FISCAL YEAR 1975

As the result of the passage of Public Law 93-647, the Social Service Amendments of 1974, there will be greater concentration upon providing assistance to States with respect to the content of their service program, and their service program planning, reporting, administration and evaluation as States develop their service programs in the new mode prescribed in the new Act.

While the Federal role will continue in matching State expenditures for services to the aged, among others, its responsibility for setting regulatory requirements have been curtailed, and States will assume greater responsibility for the planning and direction of their service program and its responsiveness to citizens in the State representing the aged constituency. States, with very limited exception, can determine what services they will provide, and to whom, with minimum eligibility tests for services. States must report annually upon their service programs. Federal evaluation of the State's service programs will be undertaken on a continuing basis under the new law. The emphasis, therefore, in the program will be to assist States to improve their capability to administer the service programs in a variety of ways and then to mount a continuing evaluation of the State's service program and their results and by 1977 report to Congress on the result of their efforts to assist States improve the program and evaluate the results of the State's service program as it is carried out under the new law.

3. MEDICAL ASSISTANCE PROGRAM

The Medical Assistance Program under Title XIX of the Social Security Act is a program of grants to States to assist them in providing medical services to the poor in certain categories. A major category of potentially eligible individuals is those 65 years of age and older. The program is administered by the Medical Services Administration, SRS.

States participating in the Title XIX program (and at present this includes all States except Arizona, which is scheduled to enter the program in October 1975) designate a single State agency to be responsible for the administration of the program. Generally, the assistance is administered through county or district assistance agency offices which are the point of direct contact with recipients. The State agency administers the medical assistance program in accordance with a State plan which is developed by the State agency and approved by the Administrator of SRS. The State plan enumerates the medical services to be covered by the program and must conform to the requirements and restrictions set forth in Title XIX. Every State medical assistance program must cover the following services which are commonly needed by the elderly:

—physician services
—inpatient hospital services (except in institutions for tuberculosis or mental diseases)
—outpatient hospital services
—other laboratory and X-ray services
—skilled nursing facility services for persons 21 years of age and older
—home health services.

A variety of other services are enumerated in the law which States have the option to include in their plans. Optional services which are applicable to aged individuals are:

—clinic services
—prescribed drugs
—dental services
—prosthetic devices
—eyeglasses
—private duty nursing
—physical therapy and related services
—other diagnostic, screening and preventive and rehabilitative services
—emergency hospital services
—podiatrists' services
—optometrists' services
—chiropractor's services
—care for patients 65 or older in institutions for mental disease
—care for patients 65 or older in institutions for tuberculosis
—institutional service in intermediate care facilities.

To establish eligibility under the Medicaid program, an individual must meet the categorical definitions contained in the Supplemental Security Income (SSI) program, the new Federal income maintenance program, Title XVI of the Social Security Act, which became effective January 1, 1974. To qualify for a benefit under the SSI program, an individual must meet the definition of an aged, blind or disabled individual as defined in Title XVI or, at State option, more restrictive criteria.

A second set of conditions for establishing eligibility relate to the financial eligibility criteria established by the State. For the aged, blind and disabled, these criteria are those of the SSI program, or more restrictive criteria, or those of the State's medically needy program if the State has adopted this program. The medically needy financial standards are used to determine the Medicaid eligibility of persons whose incomes are sufficient to cover basic needs, and thus are ineligible for a cash payment, but are insufficient to cover the high cost of medical care. One point regarding Medicaid eligibility for the aged, blind and disabled that must be stressed is that receipt of Title XVI benefits does not imply automatic Medicaid coverage as was the case under previous cash assistance programs. Since the States have the option of establishing eligibility criteria, it is important that precise information be secured from the State Medical Assistance Program.

The State agencies, often through the county or district assistance agencies, determine need for covered services. The local assistance agencies often assist the client in locating a provider of service; however, the initiative in seeking service generally is left to the individual. Payments for services rendered to eligible individuals are made directly to the provider of service by the State agency. Federal grants to States are a percentage of the total payments the States actually make for services under the plan. The percentage varies from 50 to 83 percent depending upon the per capita income of the State.

The elderly (65 and over) have access to these services on the same basis as all other eligible groups. They are the principal users of skilled nursing facility services intermediate care facility services and services in institutions for mental diseases. Approximately 40 percent of all Medicaid payments for all services are made on behalf of individuals 65 and older.

SPECIAL PROGRAM ACTIVITIES SERVING THE ELDERLY

Recognizing the heavy emphasis on institutional care which has developed in the Medicaid program and in keeping with the Department's objective of encouraging alternatives to institutionalization, MSA has developed and funded (in some instances in cooperation with the Administration on Aging) several projects designed to provide a complex of services to the aging. The following are programs underway at the present time:

On Lok Center

This center was established in 1972 to provide much needed geriatric services to elderly Chinese, Italian and Filipino persons living in the Chinatown-North Beach section of San Francisco. It was funded as an R & D project by SRS. There is a strong health component, with an Occupational Therapist in charge of the program. Other primary staff includes a full time Public Health Nurse, a part time physician (internist), physical therapist, nutritionist, speech therapist, and reality-recreation therapist. The program emphasizes rehabilitation but also provides much needed maintenance services. Eighty percent of the participants are over 70 years old. Most of the participants have medical problems that require supervision on a sustained basis.

Mosholu-Montefiore Day Care for Elderly

This program is located in Bronx, New York, on the grounds of the Montefiore Hospital and Medical Center. This program was funded by SRS in 1972 as an R & D project. The staff is composed of one Director (MSW), three aides, one social worker, one counseling specialist, one RN, one LPN, one OT, and one secretary, all full-time. The physician is part-time. The program uses the facilities of an existing institution (the Monetfiore Center) for the meals and social programs. The daily health care of the participants is supervised by the RN and LPN. Procedures for special care, such as physical therapy or emergency treatment are provided by staff of the Montefiore Hospital or Community Center. Recreational activities based on a participant's medical needs and interests are provided as a part of the daily schedule.

St. Camillus

This facility, located in Syracuse, New York, is a 130-bed skilled nursing facility which also offers a wide range of outpatient services such as occupational therapy, physical therapy pulmonary care, diabetic care and arthritic care. The day care program is operated as an independent program; however, patients admitted to the day care program receive most of their services from the St. Camillus Outpatient Department. The primary staff is composed of a registered nurse, social worker, and administrative and clerical personnel. Other staff are shared by St. Camillus SNF and the Day Treatment Program.

Patients must have their own physicians. Day Center personnel work cooperatively with each patient's physician to develop a care plan and obtain written orders. Care plans and physicians' orders are reviewed by day center staff with the private physician at least every 30 days. The Medicaid rate is $12.60 per day, excluding transportation. Transportation costs vary with arrangements. Currently, taxi rates are about $5 per patient per day. There are approximately 45 persons in this program.

Burke Day Hospital

This program operates like a subsidiary of the Burke Rehabilitation Hospital of White Plains, New York. Although the day hospital is an independent program, the administrative staff has contracted with the Burke Hospital to utilize many of its services.

The Day Hospital is distinguished from the programs described above in two ways.

(a) The patients served generally have more chronic medical problems and

(b) Diagnostic and treatment services are more sophisticated. Convenient access to the Burke Hospital treatment facilities permits employment of these sophisticated diagnostic and treatment services such as radiological therapy, hydro therapy or electroencephalography for the day hospital patients.

The physician for the day hospital is a member of the Burke Hospital medical staff and is part-time for the day hospital. Other primary staff includes a registered nurse, licensed practical nurse, physical therapist, occupational therapist, speech therapist and recreation therapist. The program emphasizes rehabilitation and is vitally concerned with patients who have chronic medical conditions and require an intensive maintenance program to keep them from being hospitalized for long periods of time.

Wisconsin Community Care Organization

This program's overall objective is to demonstrate that a substantial segment of the elderly and functionally disabled population may be maintained in their own homes at a cost lower than that of the present pattern of institutionalization through the provision of a packaged continuum of health and health related social services, such as meals on wheels.[1] An inherent premise of this objective is the belief that this population would prefer to continue to live at home if possible. This premise as well as the overall objective will be tested as a part of the project evaluation.

The CCO seeks to demonstrate that quality of care can be improved over that which is the experience in the current Medical Assistance Program by introduction of interventionary health related social services and limited health services as offered by the CCO. This objective is based in part on data cited on accelerated rates of debilitation following institutionalization, studies on debilitation as a result of inappropriate placement and the experience of health maintenance organizations in reducing the demand for acute care services by early provision of lower level health services. Again, this premise will be tested as part of the evaluation design. Specific indices will be examined in the CCO population in contrast to a control population in the current system to test achievement of this objective.

OFFICE OF EDUCATION

Office of Education activities for the older American are concentrated in three areas: Adult Education, Community Services and Continuing Education, Public Library Services.

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[1] Housekeeping aid and transportation.

1. Adult Education

The adult education program authorized under the Adult Education Act of 1966, as amended, provides undereducated adults (persons 16 years of age and older) an opportunity to continue their education to at least the level of completion of secondary school and makes available the means to secure training that will enable them to become more employable, productive, and responsible citizens.

The program is a State grant operation administered by State education agencies according to State plans submitted to the U.S. Office of Education and approved by the U.S. Commissioner of Education. States are allowed grants to pay the Federal share of the cost of establishing or expanding adult education programs in local educational agencies and private nonprofit agencies. The matching requirement for the State grant program is 90 percent Federal funds and 10 percent State and/or local funds.

The fiscal year 1973 reports indicate the following age distribution of participants in the adult education program:

	Actual 1973	Estimate 1974
Age group:		
16 to 24	290,710	343,993
25 to 34	222,522	263,245
35 to 44	144,740	171,278
45 to 54	84,634	100,120
55 to 64	44,339	52,457
65 and over	23,564	27,907
Total	810,509	959,000

Public Law 93–29 amended the Adult Education Act by authorizing the Commissioner to make grants to State and local educational agencies or other public or private nonprofit agencies for programs to further the purpose of this Act by providing educational programs for elderly persons whose ability to speak and read the English language is limited and who live in an area with a culture different than their own. Such programs shall be designed to equip such elderly persons to deal successfully with the practical problems in their everyday life, including the making of purchases, meeting their transportation and housing needs, and complying with governmental requirements such as those for obtaining citizenship, public assistance and social security benefits, and housing.

However, to date no appropriations have been made to implement this section.

2. Community Service and Continuing Education

Title I of the Higher Education Act of 1965 (Public Law 89–329, as amended) authorizes grants to the 50 States, the District of Columbia, Guam, American Samoa, the Commonwealth of Puerto Rico, and the Virgin Islands. The intent of these grants is to strengthen the community service programs of colleges and universities for the purpose of assisting in the solution of community problems. The program is administered in each State by an agency designated by the Governor, under a State Plan approved by the U.S. Commissioner of Education. The State agency establishes program priorities and approves and funds institutional proposals. Funds are provided on a 66⅔ Federal and 33⅓ non-Federal basis. A community services project under this Act means an educational program, activity or service, including research programs and university extension or continuing education offerings.

The *State-Grant Program* has supported a number of projects designed to assist the older American. During 1974 an estimated 30,000 elderly persons in 27 States participated in 41 such projects. Activities included training programs for professional and para-professional staff of nursing homes; pre-retirement and retirement counseling; consumer education; and informational programs regarding Medicare/Medicaid benefits and housing assistance.

Special Projects, authorized by Section 106, permit the Commissioner to reserve 10 percent of the sums appropriated in order to support special projects which are designed to seek solutions to "national and regional problems relating to technological and social changes and environmental pollution." Such special activities are limited to demonstration or experimental efforts. Projects must be based on a design for and the implementation of organized continuing education activity for adults. In 1974, the first year of implementation, two special projects for the aging were supported.

An award of $144,491 was made to the Andrus Gerontology Center of the University of Southern California for a Pre-Retirement Education Project (P.R.E.P.). This project has established a broadly based community consortium involving various levels of educational institutions, private organizations, private industry and organized labor. The consortium is responsible for the development of a pre-retirement educational model and for the training of personnel for indepth pre- and post-retirement counseling. The model will grow out of the testing and evaluation of three existing pre-retirement programs. After completion of the pre-retirement education of approximately 500 individuals and their spouses, the strengths and weaknesses of the programs will be evaluated and a model program developed, tested, and disseminated.

The Institute of Gerontology (The University of Michigan-Wayne State University) is using $84,890 in Title I funds to develop post-retirement education model programs in cooperation with a consortium of community colleges in Wayne County, Michigan. Drawing upon the resources of all the institutions and communities represented, the project aims at enabling older adults to acquire knowledge and skills that will help them to live in dignity and with purpose in their communities. A series of model programs for elderly persons of divergent economic and ethnic backgrounds is to be designed, implemented and evaluated. The participating community colleges include: Wayne County Community College and Highland Park Community College, both located in the City of Detroit and Highland Park; Henry Ford Community College located in Dearborn (suburban Detroit) and; Schoolcraft College situated in Livonia (servicing residents from several small townships and urban communities).

Special Projects for the Elderly. Title VIII of the Older Americans Comprehensive Services Amendments of 1973 further amended Title I, HEA to authorize the Commissioner to make grants to institutions of higher education to assist them in carrying out programs specifically designed to apply the resources of higher education to the problems of the elderly, particularly with regard to transportation and housing problems of elderly persons living in rural and isolated areas. For the purpose of making these grants the Act authorized to be appropriated "such sums as may be necessary." No funds have been appropriated for this section.

FUNDING

Congress determines the appropriations annually. Of the sums appropriated the Commissioner may reserve 10 percent for special project discretionary grants, and allot $25,000 each to Guam, American Samoa, Puerto Rico, and the Virgin Islands and $100,000 to each of the States and the District of Columbia. The remainder is distributed on a population ratio basis. Total appropriations for Fiscal Year 1974: $14.25 million.

3. Public Library Services

Office of Education support for library and information services for the aging during 1974 included a variety of activities ranging from talking bookmobile services to development and implementation of services to the institutionalized and handicapped. The projects have been funded primarily by the Library Services and Construction Act (LSCA) and the Higher Education Act of 1965, Title II–B.

Emphasis on the concern for the older American has been shown by the efforts to study the information needs of the aging, identify those persons who constitute the population segment for which these services may be appropriate, and the design of programs which will be effective and useful to this target group. In a national study, conducted in 1973 and supported by LSCA, it was learned that the elderly reader represents one of the highest user groups of public library services. The 1973 study also indicated the older patron's concern for improvement of library and information services. These suggestions were made: (1) the services should be more accessible; (2) transportation should be provided for older patrons; and (3) books and materials should be delivered to the neighborhood.

In 1974, isolated and rural as well as immobilized elderly persons benefitted from the increase of books-by-mail programs, provided by libraries at no cost to the users who select their reading from mailed book catalogs.

A survey of the literature (supported by a HEA, II–B demonstration grant—completed in 1973) describes the information needs of the disadvantaged and includes the following comments:

> "Due to the depleted financial resources, the Aging American is forced to rely more on public programs for life support . . . There is a critical need for information services that will dispense information on the various social agencies and their programs in an aggressive manner . . ."

The notable development of public libraries as information and referral centers is helping to give coping and survival skills to older persons thereby connecting them with services crucial to their well-being.

Approximately 40,000 (LSCA programs only) older Americans are participating in programs specifically designed for the physically handicapped. Both the LSCA and the Library of Congress Program for the Physically Handicapped include large numbers of elderly handicapped persons: they account for a major portion of readers of talking books, braille and other special reading materials available on loan through a network of 52 regional and subregional libraries for the blind and physically handicapped throughout the country.

Librarians seek to involve older persons by direct visits to shut-ins; books by mail; telephone information services; free telephone services to Regional Libraries for the Handicapped; group programs (films on travel, consumer education, and other subjects, lectures, demonstrations, discussions, concerts, art exhibits, crafts, hobby shows, etc.), employment programs; and free transportation to the libraries. In addition to the number of libraries that are offering free-busing for elderly residents, more are experimenting with this service and providing with it special group programs to give impetus to participation. The growth of library-based independent learning programs in 1974 opened up opportunities for purposeful guided study at the senior citizen's individual pace, educational level and convenience.

To cite an example, in Boone, Iowa, the Erikson Public Library planned a program and named it "Old Settler's Library", for 2,500 senior citizens living in the oldest section of the city together with 1,800 people receiving public assistance. A rented store front building has become a library center with a special array of print and non-print materials, including cassettes and magazines in large print. It is also used as a senior citizen center, for meetings, socializing, and for assistance to those who want to study independently, gain high school equivalency accreditation, learn a craft, or train for a job, with the help of the Community College staff and volunteer groups. All age groups are welcomed by "Old Settler's Library," but especially those users from the three homes for the aging in the neighborhood.

LSCA funds are used to develop programs to identify eligible readers and acquaint them with available services; to buy large print materials, commercially recorded materials and reading aids; conduct programs for recording materials in Indian, Spanish, Canadian-French, Polynesian and other native languages; and for staff and equipment. In Arizona, for example, the Easter Seal Society and the Desert Regional Library jointly operate a talking bookmobile throughout the State to promote talking books and enroll new borrowers—elderly readers are the principal patrons.

Future plans for library and information services for the aging include the refinement and implementation of model programs developed during the year and the continuation of established services and programs. The 1973 amendments to the Older Americans Act include opportunities for strengthening library services to older adults. Until such time as the "Older Reader Services" amendment is funded, assistance will continue from the general service of the Library Services and Construction Act, Title I.

NATIONAL INSTITUTE OF EDUCATION

During 1974 the National Institute of Education conducted a study on educational services for older people and drafted a report of that study which will soon be published.

The report, "A Program Planning Guide for Educational Services to the Elderly," cites the neglect and the destructive stereotypes about older persons and challenges the education community to chart a new course for the elderly. Community colleges, the report suggests, may be the ideal means of doing so because they are community-based and public supported. In addition, community colleges have demonstrated their flexibility in program content, teaching styles, use of off-campus facilities, and special outreach recruitment efforts.

For the community college administrator, the report provides a comprehensive and specific program planning guide. Included are sample letters to survey the interests of the elderly, suggested contact points to reach the elderly in the community, and a list of agencies and groups that can provide more specific information, such as sources for funding. Crucial to the success of any program, the report points out, is the involvement of the elderly in the planning process.

The Institute anticipates that this report, by bringing together the latest research and new ideas on this pressing problem, will help administrators and communities start educational programs for the elderly.

PUBLIC HEALTH SERVICE

PREFACE

The following report on the Public Health Service activities in aging presents the major accomplishments for 1974 and anticipated program directions for 1975. In preparing the report, an attempt has been made to highlight our efforts to (1) assure quality nursing home care for the elderly, (2) coordinate the implementation of long-term care standards, (3) protect the aged in their role as consumers, (4) perform and support biomedical and behavioral research into aging, (5) provide and fund for the health care needs of communities, of which the elderly are a part, (6) assure quality care to Medicare and Medicaid beneficiaries through implementation of the PSRO program, and (7) support research on the development, organization, and delivery of long-term care health services. With the establishment of the new National Institute on Aging within NIH and the addition of new responsibilities to the Office of Nursing Home Affairs, the PHS expects to provide an even stronger complement to the Department's Administration on Aging.

A. OFFICE OF NURSING HOME AFFAIRS

Organizational and structural changes.—On August 30, 1974, the *Federal Register* published the revised Statement of Organization, Functions, and Delegations of Authority of the Office of Nursing Home Affairs (ONHA). ONHA had been operating under this structure since early in the year. To the original responsibility for serving as the Departmental and PHS focal point for nursing home affairs, called for by the President's Nursing Home Directives of August 1971, ONHA was also given responsibility to serve as the focal point for long-term care (LTC) and for the ASH's responsibilities in Departmental programs on aging. Since the publication of the statement, a further responsibility has been delegated to ONHA, that of coordinating development of a comprehensive-interagency objective to expand both beneficiaries and services covered by home health care.

The two Divisions created in ONHA are the Division of Standards Enforcement Coordination and the Division of Policy Development. The former is responsible for assuring consistent application and enforcement of LTC standards and receives and analyzes reports of regional monitoring of survey/certification activities in order to evaluate progress of correction of deficiencies and to give timely, responsive technical assistance in implementing standards. The latter division recommends, develops, interprets and clarifies policies that impact on levels, ranges, and quality of institutional and non-institutional long-term care and on facility improvement.

In addition to being broadly involved and working closely with PHS and Departmental agencies in the Headquarters area, ONHA works directly with the Offices of Long Term Care Standards Enforcement (OLTCSE) in all of the Regional Offices to advise and administer the activities relating both to the approval and termination of agreements with skilled nursing facilities (SNF's) participating in Medicare and Medicaid programs. These offices are established within the Office of the Regional Directors. Their responsibilities in carrying out the authority delegated by the Secretary in monitoring State survey/certification activities is described in the *Federal Register* for June 13, 1974. Senior staff members of ONHA meet every 3 or 4 months with the Directors of

Regional OLTCSE to participate in their orientation to the outpouring of new regulations and to review issues still presenting difficulties in the field.

To assure a free flow of information and communication among all of the involved agencies, an Intra-agency Advisory Group meets regularly to report on assigned tasks and recommend priority action areas. Currently involved in aspects of long term care and aging are: the Bureau of Health Insurance of the Social Security Administration; Medical Services Administration of Social and Rehabilitation Service; Bureau of Quality Assurance of Health Services Administration; National Center for Health Statistics; Comprehensive Health Planning Service, Health Care Facilities Service (Hill-Burton), and the Bureau of Health Services Research, all of Health Resources Administration; National Institute of Mental Health of the Alcohol, Drug Abuse, and Mental Health Administration; National Institute of Child Health and Human Development, National Institutes of Health; Administration on Aging; Office of Facilities Engineering and Property Management; the Office of Education; and the Bureau of Health Resources Development.

The foregoing are all DHEW agencies. Other Federal departments having concern with long-term care and aging are: The Department of Housing and Urban Development; the Veterans Administration; the Department of Transportation; the Department of Labor; and the U.S. Department of Agriculture. One or two Directors of Regional OLTCSE also attend these meetings, and report for and back to the other Directors. The special assistant to the Secretary co-chaired these meetings with the Director of the Office of Nursing Home Affairs.

PART I. THE NURSING HOME IMPROVEMENT INITIATIVES

Many of the original eight-point Nursing Home Improvement Initiatives, enunciated by then President Nixon in 1971 to improve the quality of life and care of elderly and disabled needing long-term care, have been accomplished. However, just as the responsibilities of ONHA have expanded, emphasis of the original initiatives (which included standards development and enforcement, surveyor and care personnel training, mechanisms responsive to consumer complaints, and research development and data collection efforts) have been modified and expanded to reflect current crises in nursing home care.

While responsibilities for program aspects of implementing these expanded initiatives are now scattered throughout H (BQA/HSA, DLTC/HRA and NIMH/ADAMHA), BHI/SSA, MSA/SRS, and AoA/OHD, and will be reported on directly by these agencies, the role of ONHA has been to stimulate, coordinate, obtain concurrence and clearance, and thereafter to clarify and enforce and evaluate, as outlined in the organizational statement referred to above.

A. DEVELOPMENT OF UNIFORM STANDARDS FOR SKILLED NURSING FACILITIES (SNF'S)

In January 1974, uniform Federal regulations governing participation of skilled nursing facilities in titles XVIII and XIX were published, and interpretive guidelines for professional and consumer groups as well as instructional guidelines and forms for surveyors were developed. The process by which these are developed seeks to assure that standards are reasonable, yet adhere to sound professional practice. The regulations provide a streamlined efficient mechanism for inspecting and certifying nursing homes receiving Federal funds and places special emphasis on the health and safety of patients.

On October 3, 1974, additional standards were published in final form after having been published as proposals on May 1 for comment.

Requirements for medical direction, 7-day registered nurse coverage, discharge planning and patients' rights were established, and again the process of developing guidelines and survey forms was repeated. These four standards have been long awaited to enhance the quality of care and life that ONHA and the Department had made a commitment to improve.

B. CONSUMER/PROVIDER INTEREST IN NURSING HOME CONDITIONS AND FEDERAL STANDARDS

More comments were received about the rights of married couples to be together in a LTC facility than any other proposal. The "patients bill of rights" in general received a large proportion of attention (similar regulations are being developed for intermediate care facilities). This was not unusual in a year marked from beginning to end with emotion-laden articles on abuses in nursing homes—including Mary Adelaide Mendelson's book, "*Tender Loving Greed*," and the report of the Subcommittee on LTC of the Senate Special Committee on Aging, "Nursing Home Care—Failure of Public Policy." All of these publications drew on material that pre-dated the Department's vigorous improvement programs and did not sufficiently reflect actions being taken to ensure improved care, reports of which are readily available.

One approach used effectively by ONHA to disseminate information about Federal actions in the LTC field has been the "Open Forum" meetings, to which provider, consumer and professional associations are invited to learn about new regulations and make inputs into the guidelines. Groups such as the Gray Panthers and the National Council of Senior Citizens have participated. Forums were conducted in March and in November 1974.

The publicity level achieved by nursing home concerns has increased the already large number of complaints received regularly from individuals or through Congress and the White House. Regional OLTCSE work closely with State agencies in exploring these complaints and unannounced survey visits are arranged, if indicated, to investigate.

The interest of concerned individuals, families, groups, congressional committees and communities (whatever the trigger) has been interpreted as a very healthy aspect in improving nursing home care, as the sense of community presence in homes will not only aid in assuring humane treatment but also in reassuring patient care staff and residents themselves that they are not a forgotten segment of the population. This interest has also lead to several televised appearances of the Director, ONHA, during which issues in and approaches to improved care have been discussed with consumer, provider and congressional representatives. All these activities raise the level of awareness of the public about the need for concerted efforts of all groups to accomplish a task of great magnitude.

C. DEVELOPMENT OF OTHER REGULATIONS AFFECTING QUALITY OF CARE AND PROVIDER IMPROVEMENT

1. In January, 1974, the regulations governing *intermediate care facilities* (ICF's) were published, creating in response to congressional legislation, a new level of care to be provided under the Medicaid program. Prior to the publication of final regulations for this category of provider institution, many States had used their own discretion in using Medicaid funds to support individuals in facilities which do not offer the ICF level of care or cannot meet the new requirements for Federal financial participation (FFP). The certification procedures developed for SNF's also apply to ICF's. Regulations effective March 1974, require that each facility be surveyed and certified for participation in the Medicaid program within one year. About 60 percent of the participating ICF's were surveyed in 1974.

Regional Offices are cognizant of the assistance needed by States and agencies as changes in level of care provided by facilities result from implementation of regulations. Although too early to predict nationwide trends, the phenomenon of SNF's under title XVIII and XIX converting to ICF's has program implications, and raises the critical question of impact on patients' needs for care. The following issues are being studied: the reasons behind conversions, patient versus facility reclassification, and impact of appropriate ratio of SNF's to ICF's required to meet care needs.

Policies governing the preparation of patients for any transfers necessitated by decertification or recertification at another level have been developed and circulated by ONHA as guidelines for procedures to ease the stresses of relocation.

Guidelines and survey forms were developed for ICF's too, including special forms for needs of intermediate care facilities for the mentally retarded (ICF/MR) and developmentally disabled. BQA, which has a lead role in interagency work groups developing guidelines and forms, projects training needs which new regulations will require and plans expanded activities to sensitize and alert surveyors to special needs of MR patients and facilities and upgrade technical assistance to providers.

Operations manuals for Regional and State officials were developed for SNF, ICF and ICF/MR regulations.

2. Working with DHEW, the Department of Housing and Urban Development established a *guaranteed loan program* called for by P.L. 93–204. Provisions of the program, published in the *Federal Register* of August 12, 1974 will assist facility administrators to purchase and install fire safety equipment which would enable them to meet the life safety code (LSC) requirements of the SNF and ICF regulations. Procedures for applications have been designed.

3. Regulations governing SNF's and ICF's participating in Medicare and Medicaid were issued on November 29, to become effective February 1, 1975. These regulations were mandated by P.L. 92–603, and govern hospitals and mental hospitals as well as SNF's and ICF's. Many regulations pertain to all facilities, but the guidelines that are being developed for long-term care facilities will be different from those for short stay hospitals. Functional considerations must be considered as well as diagnoses in developing criteria and norms for extended stays. All facilities should benefit from review of the appropriateness and timeliness and quality of care, and from the requirements to study some aspect of their medical care practice. These regulations are compatible with the operations of Professionals Standards Review Organizations, which are increasing in number and should be operational throughout the country in about two more years and able eventually to perform review functions.

4. Definitions and criteria for determining need for the *skilled level of nursing care* were completed in 1974 by an interagency work group chaired by ONHA staff. The proposed regulations, which will serve as interim regulations as well, are being readied for publication. These regulations will provide further assurance that proper placement is made and will bring into closer uniformity the definitions of titles XVIII and XIX.

D. ENFORCEMENT ISSUES

A longstanding problem in the administration of the largely State controlled Medicaid program was addressed in investigations which are proving to be effective. Cooperative efforts of Federal and State agencies concerned are providing a mechanism for uncovering areas of abuse and terminating Federal financial participation.

E. LIFE SAFETY CODE

During 1974, major emphasis was placed in improving the enforcement of Life Safety Code requirements in Skilled Nursing Facilities and Intermediate Care Facilities. In January 1974, final regulations were issued implementing the LSC for Intermediate Care Facilities. In July and August three Life Safety Code Survey training sessions were held for State and Regional Office personnel. Approximately 230 State people attended these sessions which were geared to improving interpretation and documentation requirements and survey techniques. In addition, a contract was entered into with an outside consultant for the development of an audio-visual training program which can be used by State survey personnel to improve their understanding and application of LSC requirements.

The Department worked closely with HUD in implementing the provisions of P.L. 93–204 which authorized FHA insurance on loans to nursing homes for the purchase and installation of fire safety equipment. A handbook was developed explaining the requirements and procedures for obtaining FHA insurance.

Our Regional offices of Long-Term Care Standards Enforcement conducted periodic training sessions for State surveyors and continued to perform validation surveys throughout the year. This effort has resulted in more uniform interpretation of LSC requirements and stricter enforcement.

F. OMBUDSMAN DEMONSTRATIONS AND ACTIVITIES IN AGING

The seven nursing home ombudsman demonstration projects which were transferred from ONHA to the Administration on Aging (AoA) in 1973 are fully operational. An assessment of the experiences of the various models for resolving grievances is underway. The information gleaned will be useful as AoA expands its advocacy role for aging.

A joint agreement between PHS (ONHA) and AoA developed in 1974 smoothes the way for the expertise of health professionals to be made available at Central and Regional office level, to assist staff of State and area Aging Programs to address health and mental health aspects of LTC. Some of the priority AoA areas already identified during 1974 for joint attention are information and referral programs and an information clearing house.

The ASH assigned ONHA the responsibility for coordinating the health agencies' aging activities related to implementation of P.L. 93-296 which established the National Institute on Aging. Particular attention is being given to the coordination of research and training activities. An Interagency Committee composed of all health agencies and AoA is assigning responsibilities to appropriate agencies to preclude potential overlaps.

AoA has been delegated primary responsibility for patient relocation from substandard facilities, and can lend skills to identify service gaps and strengthen community resources. As noted earlier, ONHA has undertaken the lead health role and has circulated guidelines to assist ROLTCSE to provide consultations to State relocation efforts. Activities are to be coordinated with financing agencies.

G. SURVEYOR TRAINING

On August 7, 1974, P.L. 93-368 extended for three years (until June 30, 1977) the 100 percent Federal funding of salaries and training of surveyors of long-term care facilities, in accordance with recommendations that continued support was needed to insure that States could complete inspections required to certify facilities and assist them to maintain compliance with regulations.

During 1974, ongoing health facility surveyor training (BQA/HSA) provided opportunities for 60 surveyors to attend supervisory courses, 180 the advanced course, and 315 the basic. Over 2,000 surveyor personnel have attended these specialized courses to date. In addition, Regional Office meetings were held in January and February to orient staff to new SNF and ICF regulations, and five Regional Office meetings in the fall oriented staff to special MR issues. Programmed instruction materials for State surveyors, in preparation for the basic training course produced through a university contract, are being made available. Each Region has a Health Facility Surveyor Improvement Program coordinator to identify specific needs in that area for surveyor training.

H. PROVIDER TRAINING

In 1974, through contracts awarded by the Division of Long-Term Care, National Center for Health Services Research, HRA, patient care personnel throughout the country, representing all categories, were provided with opportunities for short term training. This brought to 74,000 the total reached by such opportunities since this initiative was implemented. Long-Term Care coordinators have been designated in all DHEW regions, and 9 regions have identified a "center of excellence" within their jurisdiction, a long-term care facility where on-site training can be given to interdisciplinary teams from other facilities. Materials from earlier contracts have been produced for distribution.

I. DEVELOPMENT AND DATA COLLECTION

Through contracts and grants, studies are being conducted by the DHEW in the areas of (1) quality of care, (2) assessment of alternatives to institutional care, and (3) data collection. ONHA coordinates these efforts throughout the Department to avoid duplication.

During 1974, the nationwide sample survey of nursing homes, their residents, and staff, was completed by the National Center for Health Statistics. Provisional data (including cost data) based on a subsample (nearly 300 of the 2,112 homes included in the survey) was published in September in the Center's *Vital Statistics Report.* Final estimates based on the entire sample are currently being prepared for publication. Surveys are planned on a continuing basis for every 2 years. This means that essential trend information as well as current estimates on this rapidly expanding sector of the health care delivery system will be available for planning, providing and establishing standards for long-term care.

Several other data programs within the Department includes long-term care information: BHI/SSA. The Bureau of Health Insurance (SSA), Medical Services Administration (SRS) as well as the Experimental Health Services Delivery Systems (HRA). Attention will be given to consolidating these data at headquarters and Regional Offices.

PART II. THE LONG-TERM CARE IMPROVEMENT CAMPAIGN

In addition to continued commitment to the 1971 nursing home initiatives, new ONHA strategies for assessing and increasing the nationwide level of compliance of individual facilities in the Federal Standards were developed and initiated in 1974. ONHA has set Operational Planning System (OPS) Priority Objectives for a Long-Term Care Improvement Campaign.

A. LONG-TERM CARE FACILITY IMPROVEMENT CAMPAIGN (LTCFIC)

The initial campaign project is the ongoing Long-Term Care Facility Improvement Campaign (LTCFIC). The data gathering for the project was completed during November 1974.

LTCFIC will consist of a number of discrete but related projects, each addressing one or more current problems in the long-term care field. In order to gain baseline data necessary for developing subsequent projects, the critical first step of the campaign was the survey of a scientifically selected sample of nearly 300 nursing homes throughout the nation by 15 teams of Federal health professionals who made unannounced visits.

The goals of the survey are to:

1. Demonstrate Federal presence and commitment to improve the quality and safety for the care of Older Americans particularly in nursing homes.
2. Obtain a statistically valid picture of how "good" or "bad" the situation is.
3. Support newly established Regional LTC Units to see that adequate resources are provided and personnel are trained to do the job.
4. Develop a followup program with Agencies and Regional Offices to deal with the findings of the campaign, and increase capabilities to provide technical assistance to States and providers.

Task forces composed of health professionals are now developing procedures to prepare the data for computerization and analysis preparatory to issuing a series of reports that will present the findings of the study and recommend a national strategy for addressing specific problems identified. The quality of care revealed will provide a basis for substantive planning for upgrading performances, improving survey/certification procedures, and introducing innovations in the delivery of long-term care. Implications for future national health policy and programmatic direction for LTC are anticipated from analysis of the data.

The campaign addressed other issues as well, including the following:

B. MANAGEMENT INFORMATION SYSTEM

Demands for instant information on surveys, certification, status of individual homes, Life Safety Code inspections, termination of Federal funding, and other matters of current nursing home concern have now mounted to the point where it is imperative to produce up-to-the-minute answers without delay.

The basis of a Long-Term Care Management Information System (LTC-MIS) has been developed and will begin in March 1975 to link data gathering at headquarters, regional, and State levels.

Other strategies under study in 1974 included:

C. A nationwide network of training for nursing home inspectors, leading to national credentialling of surveyors is being studied by BQA.

D. An Advisory Committee on Home Health Care, chaired by ONHA, was established in May 1974. Subsequently ONHA was delegated responsibility by ASH to coordinate and monitor home health care activities and program development for the Department. Alternatives to institutional care are urgently needed to provide more suitable care as well as to help contain health care costs. Barriers to consistency in the expansion of home health services under Medicare and Medicaid are being resolved.

E. Special needs of the mentally retarded and developmentally disabled of all ages are surfacing across the country as regulations are being implemented. Planning to provide technical assistance and consultation is underway, and will become increasingly urgent if pending legislation (S. 3378) regarding this population is enacted.

Critical issues for which future strategies are being planned include:

F. A monthly cost-of-care index to be set up and maintained by DHEW to serve in the LTC reimbursement area as the Bureau of Labor Statistics cost of living index serves to establish wage rates in other areas of the economy. Data on national and regional indices can be used to adjust DHEW formulas for reimbursement for SNF's and ICF's.

G. Grading of nursing homes uniformly throughout the Nation, using a weighted scorecard. An "A" rating for instance should reflect the same quality of care in whatever part of the country the facility is located.

H. Research required to support planning for a LTC benefit under National Health Insurance. Needs of children and disabled adults as well as elderly will be included.

B. ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

In keeping with a National Mental Health policy for the elderly promulgated by the Director of the National Institute for Mental Health (printed in the October 3, 1973, issue of the *Congressional Record*), which outlined a 10-point action program, activities were focussed to move toward the objectives. Aging was named as a priority concern of ADAMHA. Evaluation of the aging effort continued, to provide a sounder base for program planning. The Research Advisory Group to the Director of NIMH gave special study to ways of augmenting and improving the aging research program and submitted specific proposals as to how this could be done.

Plans are under way through the intramural training program at NIMH to provide an intensive seminar in mental health of the elderly. The Section on Aging of the Division of Special Mental Health Programs which provides program stimulation and encouragement in mental health program development in aging has produced two important publications.

One of these, which has received wide acclaim, is "A Social Work Guide to Long-Term Care Facilities." The other publication, which is unique in focus on the care of the mentally impaired aged, is "Aged Patients in Long-Term Care Facilities." In preparation is a manuscript which summarizes all research carried out by NIMH which is relevant to the mental health of aging persons over the period 1960 to 1974. Another publication in preparation is concerned with psychotherapy with the aged. Also in press is a publication on retirement patterns.

Manpower and training projects were funded to better equip cadres in serving the old and activities were intensified in the Division of Mental Health Service Programs to broaden utilization of community mental health centers by the elderly. Some specifics on these activities follow.

RESEARCH

The Research Advisory Group to the Director of NIMH outlined appropriate research areas for the NIMH in aging to clarify research priorities and to enable the Institute to mesh its research effort with that of the National Institute on Aging. The scope of the Committee's recommendations is best understood from the outline which is presented.

PREVENTION OF MENTAL DISEASE

1. Normal aging.
    a. Base line data important to understanding relationship of aging to development of diseases and the relative influence of aging and disease on impairment.
2. Patterns of adjustment in middle age.
3. Aging as related to change in basic psychophysical processes.
    a. Cognition.
    b. Memory.
    c. Perception.
4. Influence of psychosocial and personality factors.
    a. Life style and coping patterns.
    b. Personality factors.
    c. Interpersonal factors, e.g.—married vs. non-married, group identification, gregarious vs. isolated.
5. Environmental stresses and ecological factors.
6. Crisis points in aging.
    a. Retirement.
    b. Loss of spouse and other significant individuals.
    c. Acute medical conditions (coronary, stroke).
    d. Chronic disease (arthritis, diabetes).
7. Suicide.
8. Demography of older people.

Development and Delivery of Mental Health Services

1. Most effective use of various treatment settings and mental health facilities.
    a. Mental hospitals.
    b. Community mental health centers.
    c. General hospital.
    d. Nursing home.
    e. Providers of primary care, e.g., family physician.
2. Delivery of mental health services in non-traditional settings.
    a. Retirement villages.
    b. Specialized housing for aged.
    c. Homes for the aging.
    d. Senior citizen centers.
3. Indications for use of facilities based on individual's physical, psychological, and social disability.
4. Development and testing of innovative mental health services in long-term care facilities.
5. Organization and interrelationships of services and the agencies providing services.

Etiology, Diagnosis and Treatment of Mental Disorders

A. Etiology and Diagnosis

1. Organic brain syndrome.
    a. Need for more accurate differential diagnostic procedures with regard to both the bio-medical and psychological areas.
    b. Effect of genetic, familial, ethnic, and psychological factors with regard to development, course, and treatment of OBS ("excess disability").
2. Depression.
    a. Bio-medical factors (psychobiology).
    b. Psychosocial factors, e.g., personality, life style, methods of coping.
3. Schizophrenia.
    a. Course of schizophrenia in later life—the "burned out schizophrenic." Adjustment of chronic schizophrenic to routine protected environment.
4. Other psychiatric disorders.
5. Epidemiology and demography of above.

B. Treatment of Mental Disorders

1. Treatment modalities including psychopharmacology, psychotherapeutic techniques, milieu and environmental approaches, etc.

Services

Particular focus has been directed toward community mental health centers and public mental hospitals, the latter through the Hospital Improvement Program (HIP). Special concern has also been placed on improving the interface between these two service systems, thereby enhancing continuity of care. Work in this area represents the combined approaches of program funding, research into problems of service delivery, and technical assistance aimed at advancing the quality of care for the aging.

Further efforts toward improving mental health care for the elderly have come out of the work of an NIMH Inter-divisional Task Force on Aging. Areas of attention have included:

A. Identification of the problems and needs of older persons living in the community and institution.

B. Assembling relevant bibliographic materials.

C. Identification of resources and resource persons available to assist geriatric programs.

D. Identification of model programs serving older persons.

E. Identification of areas for clinical research, as well as for service delivery research.

F. Preparing information useful in addressing the difficult cost issues at a comprehensive geriatric program.

G. Approaches for training mental health people working with the elderly.

These areas and others are presently being adapted into program guidelines and a technical assistance package that will be available to CMHC's, hospitals, and other providers. This material could also be relevant with regard to any future legislation impacting on older persons.

In addition to the work of the NIMH Interdivisional Task Force on Aging, a recent-established NIMH Work Group on Community Support is giving special attention to the need to increase the availability of alternatives to institutional care for mentally impaired older people. The Work Group is particularly interested in exploring strategies through which NIMH can join forces with other Federal and non-government agencies in making available the range of community support services necessary to maintain mentally impaired older people in satisfying lives in their own homes and communities.

MANPOWER AND TRAINING

In the Division of Manpower and Training Programs, NIMH, some 30 training institutions received funds to train manpower in aging. These included schools of social work, psychiatry, and the social sciences, as well as continuing education programs. One training institution was given a grant to fund a research training program in gerontology. Three additional institutions were approved for research fellowships in aging.

NATIONAL INSTITUTE ON DRUG ABUSE (NIDA)

NIDA has only recently begun to look at the problem of aging and its relationship to drug abuse. Several internal studies have been made relative to a strategy for the development of a NIDA program on aging and drug abuse. An internal committee dealing with this subject is being set up to consider the various studies that have been undertaken and to develop recommendations regarding older persons and the abuse of drugs.

STATE PROGRAM DEVELOPMENT

The State Program Development effort of the agency, designed to better respond to the mental health needs of the States, has focussed on aging as an area of potential program development. Particular emphasis has been placed on development of community supportive services to provide options to unnecessary mental hospital care. Activities are currently under way in Virginia to explore ways of improving Federal, State, and local collaboration in dealing with such areas of common concern.

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

In keeping with the intent of the *HEW Second Special Report to the U.S. Congress on Alcohol and Health* which highlighted advances in knowledge about alcohol, the National Institute on Alcohol Abuse and Alcoholism has funded two studies of the effects of alcohol on old age. One collected information on age, sex, previous drinking patterns, the use of other drugs, changes associated with retirement, illness or other major changes of life due to old age. Another compared the physical and emotional characteristics of older persons who have access to and drink alcohol with those of a group who drink but do not have access to liquor.

C. OFFICE OF POLICY DEVELOPMENT AND PLANNING, OFFICE OF ASSISTANT SECRETARY FOR HEALTH

MEDICAL DIRECTION FOR SKILLED NURSING FACILITIES

With the promulgation of a regulation requiring medical direction in Skilled Nursing Facilities under Medicare and Medicaid, the nursing home field and the medical community face a heavy challenge of implementation. Several key activities have been initiated from this office to give the field supportive participation and technical assistance.

Along with the Division of Long-Term Care of the Bureau of Health Services Research, this office has worked with the American Medical Association in planning and conducting a series of seminars on medical direction in long-term care facilities. Preparing physicians to function as medical directors and to assist physicians already in such positions, the seminars also address nursing home administrators and nurses so that the medical director's role will be mutually understood and supported. This participation with the AMA continues.

Suggestive materials are being culled from the literature to bring together concepts of medical direction and reported experience with such activity in nursing homes. Arrangements are being pursued to issue such materials in a form that will be useful to the field in developing provisions for medical direction.

With the urgency of need for technical assistance to nursing homes and physicians in developing medical direction arrangements in skilled nursing facilities across the country, this office has generated a search for existing examples of medical direction in practice. A variety of illustrative arrangements and prototypes will be identified and described, and made available as guide materials to the field.

This office is additionally undertaking to organize, with the coordinated participation of concerned agencies of the department, a plan for evaluating alternative models of medical direction in nursing homes. Thus, current experience in this emergent role of medical direction will become the stepping stones to appropriate modifications and improvement of this key element of nursing home care.

LONG-TERM CARE BENEFITS IN EXISTING HMO'S

New health maintenance organizations that are forming and earlier prepaid group practices that have not undertaken significantly to provide long-term care benefits in the past are coming into an era where long-term care needs cannot be sidestepped. A few of the existing health maintenance organizations have, however, involved themselves in various ways and to varying degrees in provision of definitive long-term care benefits such as nursing home care and home health services. Contacts have been initiated in an exploratory look at what exists of such types of provisions among the limited number of operating "HMO's" that have had some experience with furnishing long-term care. This, hopefully, will lead to an informed approach to developing a structured inventory and assessment of existing experience and costs. Such data and evaluation will be of immediate use to health maintenance organizations in their development or refinement of their benefit package. Clearly, such material will also be highly useful in consideration of possible benefits under national health insurance.

D. NATIONAL INSTITUTE ON AGING

INTRODUCTION

On May 31, 1974, Congress authorized the establishment of the National Institute on Aging to "conduct and support biomedical, social, and behavioral research and training related to the aging process and the diseases and other special problems and needs of the aging."

The Secretary of the Department of Health, Education, and Welfare, officially established the new Institute on October 7, 1974.

The nucleus of the Institute's program will be the research and training programs transferred to it from the National Institute of Child Health and Human Development.

RESEARCH IN AGING—FISCAL YEAR 1975

INTRAMURAL RESEARCH

The Gerontology Research Center situated in Baltimore, Maryland, and part of the NICHD, conducts basic and clinical research in these main areas: clinical physiology, molecular aging, behavioral sciences, and cellular and comparative physiology.

Longitudinal Study

In fiscal year 1975, the eighth, 2-year cycle of testing in the Longitudinal Study of Human Aging, will be completed. The most comprehensive analysis of the physiology of human aging ever undertaken, the diversity of studies is made possible by a remarkable group of 650 volunteers ranging in age from 20 to 90 years, who spend 2⅓ days as subjects at the Center and who return for testing every 1 to 2 years depending upon their age. Results to date have provided the most reliable data on the definition of "normal aging" for many functions which are not only of importance to theories of aging but also to proper diagnosis and care of middle-aged and older patients.

In the past year, for example, studies have been completed of the effect of age on the metabolism or disposition of drugs (medications) by the body. But studies of possible age differences in the metabolism of alcohol and in the effects of alcohol on cognitive function and on physical performance have been almost totally neglected. It has been found that, unlike other chemicals, the disposition of alcohol does not change with age, but its effects on measures of attention, memory, and decision time are more severe in the aged. The concepts of a single blood level of alcohol which defines the intoxicated state may need to be adjusted to allow for these age differences in alcohol effect.

In a study of the drug, antipyrine, it was found that the drug disappears from the blood stream more slowly as age advanced. This age difference could be shown, however, to be largely due to differences in some of the "habits" of the young and old groups. Younger men tend to smoke more, drink more coffee and tea and more alcohol, than older men. These habits, especially cigarette smoking, were shown to influence the metabolism of antipyrine significantly. Without detailed histories of these habits, we would have erroneously concluded that the primary processes of biological aging had led to changes in drug metabolism; in fact, the changes were largely secondary effects. "Habits" will now have to be taken into account in the evaluation of the clinical pharmacology of drugs.

Data from participants in the Longitudinal Study show that kidney function as measured by creatinine clearance diminished progressively with age. These observations on normal subjects show clearly that the decrease is not a reflection of the increasing prevalence of kidney disease with age but is an effect of biological aging.

From these data, a chart has been developed which enables the physician to compute easily a score for each patient as compared with normal subjects of the same age. Use of this chart will help improve the diagnosis and treatment of kidney disease in older patients.

During fiscal year 1976, continuing studies will include: analysis of data collected from repeated measurements made over the past 12 years on subjects from the Longitudinal Study with special emphasis on serum cholesterol and tryglycerides, glucose tolerance tests, measures of adiposity and cellular mass, basal metabolism, lung function, and nutritional factors; analysis of the interrelationships between the measurements made on the same subjects when analyzed longitudinally; continuation of testing under the longitudinal study; clarification of relationships among four separate diagnostic tests for diabetes; studies on cellular receptors for hormones previously carried out only in rats will be extended to human subjects; work will be done toward developing a new method for the treatment of high blood pressure (a renin inhibitor); studies on the role of the male sex hormone in proneness to heart disease and prostate hypertrophy; studies on the use of echocardiagraphy in assessing heart function in normal men of different ages; determination of the role of calcium in regulating contraction of heart muscle; and response of the heart to hormones and drugs.

Molecular Aging

Investigators at the Gerontological Research Center in their studies of physiological systems, developed techniques which may lead to an understanding of why, particularly when other diseases are present, the kidney of the elderly person fails to adapt and adjust as well as that of a younger person.

In another study, using a special device developed at the Center, scientists studied the possibility that a change in the flow of calcium between cells may be a partial cause for the deterioration of cardiac function with age.

Scientists in the laboratory of molecular aging will continue to investigate molecular events that determine the rate of aging and how these events affect individual organisms.

Behavioral Studies

The behavioral research laboratory at the Center holds a pre-eminent position in the world for the study of the clinical application of biofeedback techniques in the control of cardiac disorders. Clinical studies showed that patients with high blood pressure can be trained to lower their blood pressure through biofeedback techniques. Further research will determine specific mechanisms used by hypertensive patients to lower their blood pressure.

Patients with severe fecal incontinence secondary to organic lesions were taught to control their anal sphincters, through biofeedback techniques, and thus to become continent. These findings promise significant relief for patients with this particular problem because incontinence not only is debilitating, it also seriously affects a patient's personal life. In fact, incontinence is often the deciding factor in placing a patient in a nursing home.

Multiple studies have shown that reasoning behavior, when considered separately from memory changes, declines only in very old people. Studies have also shown that procedures can be identified which enhance learning and memory functions in the elderly.

Projected studies will explore reasoning behavior where memory is also a factor. Other studies of learning and memory will attempt to relate this behavior to physiological factors such as high blood pressure to determine whether these factors are correlated with behavioral changes.

In this program, scientists are conducting studies on the nature of the age-dated deterioration of cells of the immune and related systems and determining the underlying cellular and molecular mechanisms responsible for this deterioration; developing methods for early detection of signs of cellular aging; and, finding ways of controlling or reversing harmful changes caused by aging, which can lead to eventual cell paralysis or death.

The thymus, which generates T-lymphocytes, goes through a degenerative change throughout life after sexual maturity in mice and men. This degeneration is followed by a gradual decline in certain immune functions. Studies at the Center have revealed that, for the most part, the degenerative changes are reversible. Based on this information, it is possible that a reasonable approach may be found for delaying the decline in these immune functions.

A systematic series of studies has been initiated to correct the immuno-deficiency state of old animals. Preliminary results indicate that certain immune functions can be rejuvenated by two different approaches: (1) the injection of a pharmacological agent; and (2) the transplantation of young thymuses and the injection of young stem cells from bone marrow.

The immune system, which is intimately involved with adaptation of the body to environmental stress and change, declines in its efficiency with increasing age. Associated with this decline is the rise in susceptibility to diseases such as infection caused by viruses and fungi, cancer, and self-destructive autoimmune diseases. Scientists in this laboratory may be able to delay, reverse, or prevent the decline in normal immune functions. This in turn may delay the onset or lessen the severity of diseases accompanying old age.

EXTRAMURAL RESEARCH

In the past year, 93 grants supported a variety of research projects in universities and other institutions. Of these projects, 19 were multidisciplinary programs, including a research center at Duke University. Nineteen training grants supported 147 trainees; fellowships supported 29 young scientists.

Immunological Changes in Aging

The body's immune system is at its peak of efficiency at, or even slightly before, puberty. From then on, the efficiency of the immune system goes down hill, making middle-aged and older people particularly susceptible to infectious diseases. There is also evidence that immunologic competence is an important factor in preventing the development of cancer and certain autoimmune diseases such as rheumatoid arthritis. Research in the field of aging in 1974 included investigations of aging and immune responses to transplants and tumors, the role of immunosuppressants in aging, autoimmunity, and immunogenetics of aging.

Cellular Aging

Though endocrine and immune systems may be modified to control some aging manifestations, an even more vigorous intervention might be possible at the cellular and subcellular levels if more were understood about cellular aging. It was thought at one time that the dividing cells in the human body were immortal, but modern research has disproved that theory: normal cells will not reproduce themselves indefinitely.

As the body ages, skin thins and becomes inelastic, arteries dilate and lose elasticity, cartilage becomes friable, bones become brittle, and tendons lose tensile strength. These changes appear to arise largely from alterations in the collagen, elastin, and mucopolysaccharides that form these tissues and are made by cells called fibroblasts.

Intensive studies are being conducted on the fibroblast, the connective tissue cell similar to many dividing cells within the body. While serving as a model for other cells, fibroblasts are important in themselves as producers of substances that form structures that give mechanical support to the other cells. This area of research will be expanded to include more cell types representative of a variety of human aging phenomena.

Endocrine Change with Aging

With the onset of menopause in women and the climacteric in men, there is a decline in the body's production of hormones, thereby diminishing health and vigor and, in some instances contributing to disease and disability. Endocrine studies supported by the program on research in aging have focused on estrogen therapy in relation to the risk of strokes in post-menopausal women, properties of hormone-binding macromolecules in the liver, brain, and other tissues during development and aging, the effects of aging on steroid metabolism in man, and the effects of aging on the central nervous system.

Mental Aging

Knowledge about changes in mental function as people age is largely based on everyday observation rather than on scientific study: the speed with which children learn (and forget) new languages in contrast to adults, the importance of early training for many types of later activity, the great creativity in late adolescence and early adulthood, and senile dementia attest to changes in mental function. But in many ways this common knowledge can be misleading. Uncontrolled and even unrecognized variables may be operating that make most of what we think we know about these phenomena unreliable.

At one time, senile dementia was considered to be due mainly to cerebral arteriosclerosis. Most neuropathologists now think that this is not the case and that loss of function with age is a result of neuronal changes not dependent on vascular inadequacy. The NICHD has supported in 1974 a modest amount of research on cognitive changes that occur across the span of the adult years and some research on neurophysiological changes occurring as the central nervous system ages. A serious deficiency in the research program is the dearth of research aimed at understanding cognitive behavior in the middle and later years.

Social Aspects of Aging

Basic to developing long-range plans for the health, social, and economic welfare of older Americans is some reasonable projection of the size and composition of the population. This country's future fertility and mortality rates will determine that population's size and age structure. It is essential that appraisals be made of the effect of medical control programs on morbidity and mortality rates for particular diseases and for causes of death. Mortality rates become ever more important factors influencing population changes as fertility rates decline and the population becomes more stabilized. In line with these population concerns, the NICHD's research program has supported studies of models for forecasting future United States populations. In other sociological areas, investigations have been carried out in a cross-cultural study on the treatment of the aged, the social aspects of aging in human development, relocation in old age, and intergenerational studies of development and aging.

CONCLUSION

In fiscal year 1974, the National Institute of Child Health and Human Development spent more than $16 million on research and training in the field of aging. To set up the new National Institute on Aging, a supplemental budget for $3 million was requested in January, 1975.

Following the establishment of the NIA on October 7, 1974, an Interagency Committee was formed to assist the NIH in implementing the Research on Aging Act of 1974. The Committee's plan was submitted to the Assistant Secretary for Health in January, 1975.

A Search Committee was appointed to assist the Director of NIH in the selection of a Director for the NIA.

Nominations for the National Advisory Council on Aging have been submitted to the Secretary.

In accordance with the Act authorizing the establishment of the Institute, a plan is to be completed for a research program on aging designed to coordinate and promote research into the biological, medical, psychological, social, educational, and economic aspects of aging. This plan is to be transmitted to the Congress and to the President.

E. BUREAU OF QUALITY ASSURANCE

The Bureau of Quality Assurance is charged with two programs which have an impact on the aged population.

During fiscal year 1975 implementation of the PSRO programs will be continued. PSRO's are local organizations composed of physicians established to assure that care provided to beneficiaries of Medicare, Medicaid, and Maternal and Child Health is medically necessary, meets professionally recognized standards and is rendered in the most appropriate setting.

The Provider Standards and Certification program provides the professional health expertise to the SSA and SRS in establishing, assuring, and maintaining effective health and safety standards for providers under the financing programs.

F. BUREAU OF COMMUNITY HEALTH SERVICES

The Bureau of Community Health Services was established to help find the best ways to meet the health care needs of communities. Its goal is to ensure optimum health for the total community, with particular focus on the medically underserved areas of the nation. While the aged, per se, are not a special target population for Bureau programs they are included among the beneficiaries of overall community health improvement activities. Within the Bureau, improved health of the aged is promoted through community health centers, migrant health projects, health maintenance organizations and the National Health Service Corps.

Community health centers are designed to provide ambulatory health care services primarily for the poor and the working poor. During fiscal year 1974, a total of 157 such centers provided primary health care to approximately 1,235,000 persons. These persons reside generally in rural or inner city areas which are medically underserved. It is estimated that 6 percent of the persons registered for service in these centers are age 65 and over.

The Migrant Health Program provides access to health care services for migrant and seasonal farmworkers and their families. Migrants live and work in predominantly rural areas where health resources are scarce. As a group, the migrant family represents an underserved segment of the population in terms of most social and health services. The elderly migrant, generally uneducated, often unable to speak English, and usually incapable of participating in the work force, may present even greater needs than the rest of the migrant family. Of approximately 355,000 migrants and seasonal farmworkers who received services during 1974, it is estimated that 4,000 are 65 years of age or older.

Health Maintenance Organization (HMO) legislation was passed late in 1973 authorizing a program to demonstrate the feasibility of prepared health maintenance organizations as an alternative mechanism for delivery and financing of health services. While HMO services are available to all persons in a given geographic area who enroll in the HMO, the emphasis on accessibility, prevention, quality of care, efficiency and cost consciousness makes this health care option particularly valuable to the aged, in view of their higher-than-average utilization of services. Since the inception of the Medicare program, such prepayment plans have been authorized to request reimbursement for physician services on a cost basis. In 1974, 39 plans with a Medicare enrollment of 335,000 beneficiaries were receiving reimbursement.

Further, section 226 of the 1972 Amendments to the Social Security Act contains a provision allowing SSA to make reimbursement to HMOs for physician, hospital and other institutional services. Regulations setting forth the qualifications an organization must meet to be eligible for a Medicare HMO contract were published in the *Federal Register* as proposed rulemaking on August 27, 1974. Related regulations on reimbursement, enrollment and the like are under development.

The National Health Service Corps is designed to improve the delivery of health services to persons residing in areas with critical manpower shortages. Older people living in such areas often lack mobility and availability of health personnel in their communities is of special importance to them. The program goal is to place health professionals who will establish successful practices in shortage areas and continue to provide services in these areas. By the end of fiscal year 1974 there were a total of 405 health professionals assigned to 183 shortage area communities.

In summary, programs of the Bureau of Community Health Services, while not specifically designated for the elderly, serve all persons residing in their project areas. Many of the projects are located in areas with high concentrations of elderly persons and offer for them the only available health resource. It is the goal of the Bureau to continue its efforts to serve this needy group.

G. BUREAU OF MEDICAL SERVICES

The Bureau of Medical Services (formerly the Federal Health Programs Service) has no programs which of themselves relate directly and specifically to aging. This applies to its research and clinical care programs as well as to the programs of the Divisions of Emergency Medical Services and Federal Employee Health. For fiscal year 1974, of a total of 27,593 discharges from hospitals of the BMS, 3,783 were aged 65 or over. The average length of stay for elderly men was 23.6 days and for elderly women was 18.2 days, compared with an average length of stay of 16.8 days for all patients. Consistent with this finding is the fact that older patients are affected to a greater extent by chronic conditions which require longer periods of hospitalization, and for similar conditions, older patients tend to receive longer periods of hospital care than younger patients.

A high proportion of elderly persons receiving in-patient services are American seamen, who constitute the primary beneficiary group care for in PHS hospitals. The problems presented by this group of patients are similar to those presented by aging patients in general with one exception: there are probably more single males in this group than in the general population. Because of this, finding suitable nursing homes for their long-term care constitutes one of the real problems in meeting the needs of aging patients served by the Bureau of Medical Services.

PLANS FOR 1975

During 1975, BMS proposes to establish a Day Treatment Center for the Elderly at the USPHS Hospital in Baltimore, Md. This program will provide an alternative to institutionalization for elderly patients by providing supervision and personal care services to older persons with physical, mental or social impairment. The capacity of families to continue helping to maintain elderly relatives at home is depleted when no respite is available and institutional placement is often made not because the older person needs institutional care but because the right kinds of assistance needed do not exist. The Day Treatment Center should solve some of the difficulties of daily living, provide respite to families with elderly relatives, and enable the older person to return at night to the home setting. The aged indicate a strong preference for remaining in their homes and the Day Treatment Center would greatly assist both the family and the elderly in this regard.

The Day Treatment Center for the Elderly will be an organized program of activities and health services offered during the day in a protective group setting for purposes of personal care and designed to activate, motivate and retrain the elderly to sustain or regain maximum functional independence. The program objectives are as follows:

1. Enhance activities of daily living by providing instruction in self-care, health maintenance, consumer protection and money management and referral to other services required to assist the aged to remain in or return to their homes or communities.
2. Increase effectiveness of the individual through the service and consultation of experts not represented on the staff to develop health care plans to meet the needs of individual applicants or development of general program.
3. Improve health status by providing necessary diagnostic, remedial or treatment services and arrangements for obtaining physician or hospital services in case of emergency and by maintaining necessary liaison with other providers of health services to assure the provision of Center services necessary to carry out medical recommendations.
4. Reduce isolation by providing the means for aged persons restricted in their mobility to get out of the house: and encourage regular attendance on individually scheduled days by providing transportation incorporating safety features for the aged.
5. Promote socialization by offering companionship in a pleasant, safe and comfortable environment.

6. Stimulate interests by offering satisfying leisure time activities and discussion of common problems.

7. Conserve family interest and support by offering respite as required during part or all of the work week and by providing individual and group counselling.

Individuals participating in the Center will be aged persons referred from PHS beneficiary groups, the Geriatric Evaluation Service of the Baltimore City Health Department, community organizations and private physicians.

H. INDIAN HEALTH SERVICE

The Indian Health Program serves 498,167 Indians and Alaska Natives living in geographic and cultural isolation on 250 Reservations and in Indian communities located in 25 states, including hundreds of villages in Alaska. Based upon the 1970 U.S. Census statistics, persons aged 65 and over represent approximately 6 percent of the U.S. Indian and Alaska Native population.

The approximately 29,855 aged 65 and over and the 64,847 persons from 45 to 65 years, within the Indian Health Service population are reached through comprehensive health care provided through the Indian Health Service system of 51 hospitals, 86 field health centers, and several hundred health stations located in the vicinity of Indian family groups, and through a contract medical care program. These health and health related services covering the life span of this service population have resulted in the decline of death rate of Indian Health Service beneficiaries by 17 percent from 1955 to 1973.

In order to best utilize scarce resources to meet the many health needs of all of the 498,167 Indian Health Service population, program emphasis is directed to those in the younger age group. While attending to the health needs of the elderly, a major objective of the Indian Health Service is to advance the health level of the young and to maintain their health gains thus achieving a larger older age segment of the Indian and Alaska Native population with improved health status. From 1960 to 1970 Indian and Alaska Native persons aged 65 and over have increased by 39 percent as compared to 21 percent in the total U.S. population for the same period. Indian and Alaska Native persons aged 45 through 64 during this time period increased by 29 percent as compared with 19 percent in the Nation's total population.

Specific services provided by IHS, which minimize the health problems of the aged and aging include:

—Identification of the aging and aged and their problems by all members of the Indian Health Service staff in the course of day-to-day operations throughout Reservations and Indian communities.

—Coordinated services of the Indian Health Service physician, nurse and social work staff in meeting immediate health and social problems, preventing crises and future problems and maintaining the health gains of the elderly.

—Social assessment of the needs of the family and the lone elderly which recognizes the changing roles, functions and status of the elderly and social planning to meet their needs.

—Services of the IHS-trained Indian and Alaska Native Social Work Associates who provide a full range of social work services to their people while advancing their social work careers. These native social workers further help the elderly to interpret the differing cultural concepts of "well" and "sick" and to seek health services early.

—Development of the Indian Physician Assistant and Training Program which will extend outreach Indian health services to the elderly.

—Assistance of the Indian Health Service trained Indian Community Health Representative and the Alaska Native Community Health Aide in specially seeking out the elderly and bringing their individual problems to the attention of appropriate health and social resources, providing transportation to Indian Health Service facilities and spanning the language and cultural gap between elderly Indian patients and non-Indian professional staff when needed.

—Provision of Public Health Nursing services to 2996 individuals or more than 13 percent of the Indian service population aged 65 and over. A total of 12,400 visits were made to this group or an average four visits to each person; nursing consultation is provided to nursing homes on behalf of Indian patients, the majority of whom are elderly.

- —Counseling by IHS pharmacists to patients, with emphasis on the elderly, with chronic diseases such as diabetes and heart disease, on long-term drug therapy, who are given priority for instruction relative to the correct use of drugs and medications, and to assist the patient in understanding what to expect in results from the appropriate use of drugs.
- —Prevention of institutionalization of the senile and mentally ill elderly through mental health treatment and alternative social planning.
- —Contract health services within the funded scope of this IHS resource, providing extended medical care.
- —IHS medical and social service surveillance for nursing home and extended medical care patients.
- —Improving income levels of the elderly through application assistance for State and Federal program benefits.
- —Assisting the elderly to obtain services under such programs as Medicare, Medicaid and Veterans programs.
- —Environmental Health Services concerned with safe water supplies and waste disposal systems, vector control, home sanitation and safety, and correction of environmental conditions which adversely affect the physical and social environment of the elderly as well as the general public.
- —Nutrition and Dietetics family-centered service program of intensive education, adapting proper principles to the food habits and cultural practices of the Indian and Alaska Natives. The elderly are reached within these services to the family with special emphasis given to improving nutritional health. Individual income and the nutritional quality of diet are related. Information regarding the USDA administered Food Assistance Programs (food stamps, commodities and supplemental foods), is provided to as many of the aged as possible with special attention directed to the best possible utilization of these resources to improve the overall nutritional status. Nutrition consultation is provided to Department of Agriculture and other agencies working with Indians and Alaska Natives on educational activities and in group feeding programs.
- —IHS consultant services relative to improved and new housing for the elderly.
- —IHS consultant services to tribal groups on all phases of planning nursing home construction and operational management and services.
- —Assisting Tribes in the identification and use of all community, State and Federal financial and program services needed to attack special problems affecting the aging and aged such as grants for alcoholism and nutrition projects, and resources for the development of Home Health Aide-Homemaker Services.
- —Health Education services directed toward Indian communities, Tribal groups, families and patients including the elderly assisting the Indian people to utilize the IHS health care system, to understand the disease process and to take preventive measures which will ensure good health.

I. NATIONAL CENTER FOR HEALTH SERVICES RESEARCH

Research findings on the development, organization and delivery of long-term care health services have revealed that provision of such services to the elderly is complicated by special factors highly prevalent in this age group. Such characteristics include a multiplicity of chronic degenerative diseases (both mental and physical), as well as underlying social and economic problems.

A significant forward step that has great potential in the area of long-term care research was the passage in July 1974 of Public Law 93–353, amending the Public Health Service Act and creating a National Center for Health Services Research. The Act mandates that this Center undertake and support research, evaluation and demonstration projects (which shall be appropriately coordinated with experiments and demonstration activities authorized by the Social Security Act and the Social Security Amendments of 1967) with regard to: (1) the accessibility, acceptability, planning, organization, distribution, technology, utilization, quality, and financing of health services and systems; (2) the supply and distribution, education and training, quality, utilization, organization, and costs of health manpower; and (3) the design, construction, utilization, and costs of facilities and equipment.

The new law requires the establishment of at least six centers of health services research, including two national special emphasis centers, one to be called Health

Care Technology Center, and one to be designated the Health Care Management Center.

In the light of reorganizations during the past few years, including name changes of organizational components concerned with health services research and provider (nursing home) improvement activities, a brief historical overview might be helpful.

HISTORICAL OVERVIEW

A publication entitled, "Health Services Research and R & D in Perspective," edited by E. Evelyn Flook and Dr. Paul Sanazaro, describes the origin of Federal health services research and demonstrations, starting in 1955, and building up to the creation in 1967 of a National Center for Health Services Research and Development (NCHSRD). This book contains valuable historical information as well as extensive bibliographic references through 1973. With ear-marked funding provided for implementation of the Presidential Initiative to upgrade nursing homes, starting in 1971 support was provided by the NCHSRD for research on long-term care and aging.

In July 1973, a reorganization abolished the Health Services and Mental Health Administration (HSMHA) and created instead the Health Resources Administration (HRA) and the Health Services Administration. HRA is comprised of three major agencies: the Bureau of Health Services Research (which replaced the NCHSRD, formerly in HSMHA), the National Center for Health Statistics, and the Bureau of Health Resources Development. Although the public law mandating the creation of the new Center was enacted in July 1974, notice of the official name change from Bureau of Health Services Research to the National Center for Health Services Research was not published in the Federal Register until January 1975. *Thus, except for the following discussion of the course of action followed by the Bureau of Health Services Research in preparation for this authorization, all references in the remainder of this report to the National Center for Health Services Research and Development will relate to the former organizational entity in HSMHA, and all references to the Bureau of Health Services Research will be to the organization that in January 1975 officially became the new National Center for Health Services Research.*

1. DEVELOPMENTAL ACTIVITIES OF NEW NCHSR

The agency is under new leadership and significant changes in the mechanics for identifying research needs and funding research are being developed.

In the first stage, a two-stage planning process was pursued by the Bureau of Health Services Research, with efforts directed at identifying important but inadequately understood health care issues through consultation with legislators, policy makers, health planners and other concerned organizations and individuals. Appropriate task forces were then created such as Quality, Technology, Inflation, National Health Insurance, Emergency Medical Services, Chronic Diseases, and the Disadvantaged. Composed of appropriate non-Federal consultants and Bureau staff, the function of these task forces has been to delineate the research implications pertaining to the issues, develop appropriate researchable questions, indicate possible research methods, settings and funding mechanisms. It is anticipated that the operational tasks and activities of the strategies will then be allocated to the appropriate divisions of the Center for implementation.

The research decision process rests with the Center Director, who decides the relative strength of fiscal resources to devote to each issue in general, as well as to the distribution of funds across the research questions raised by a particular issue. Options as to funding mechanisms include contract procurement, grant stimulation and development, or in-house research, assisted by some contractual services.

In October 1974, the Bureau released a publication entitled "The Bureau of Health Services Research: A Review of Grants Procedures" that is designed to assist potential applicants.

Guidelines are being developed for potential applicants for the six research centers called for in the legislation.

The new law requires that greatly increased emphasis be given to intramural research. As an initial step toward implementation of this requirement, an Intramural Research Section has been created in the Office of the Director. Staffing presently consists of eleven professionals with expertise in economics, social psychology, statistics, law, medicine and public administration, along with support staff; large-scale expansion of this activity is anticipated in the future. Priority areas for intramural research by this component, including long-term care and health services for the aged, are currently under consideration for inclusion into this program.

The remainder of this report will relate to long-term care and aging research and provider improvement activities carried out in 1974 by the Bureau of Health Services Research.

Significantly, the Division of Long-Term Care of the BHSR was delegated prime responsibility for long-term care and aging. Selected activities in this subject area have been occasionally assigned to other Bureau divisions, and in most such instances DLTC staff have actively participated in a collaborative or supportive role.

2. DIVISION OF LONG-TERM CARE

The Division of Long-Term Care is charged with the dual functions of research and development in long-term care and aging and provider improvement activities designed to improve the quality of care in long-term care institutions by upgrading the performance of long-term care personnel through short-term training programs.

The Long-Term Care for the Elderly Research Review and Advisory Committee, established in 1973, has continued to serve as both a formal grant review panel and in an advisory capacity to the Division. The viability of this Committee has been extended to June 1976.

Program plans for 1974 included both intramural and extramural research, experiments and technical assistance directed toward the development and evaluation of innovative approaches to improve the quality of life and quality of care for the elderly and/or disabled who require long-term care services. After the models and prototypes have been tested, the staff will assist in the implementation of effective models in practice settings.

Emphasis in 1974 was placed on: (1) Measuring the quality of care, including the development of instruments to insure that the most appropriate level of care is being provided; (2) offering consumers and the public mechanisms to insure a greater and more knowledgeable voice in demanding quality of care and increased options for care; and (3) improving coordinating mechanisms for increasing the options of patients for receiving needed care in the appropriate setting through a balanced array of institutional, ambulatory and home health services, including improved administration and management procedures.

Specific areas of concentration in 1974 included intensified activity in relation to implementation of Section 222 of Public Law 92–603 in developing demonstrations to determine cost-effectiveness of day care, homemaker service and intermediate care, further testing of the Collaborative Patient Assessment Instrument, development of a cost data reporting system for Nursing Home Care, exporting a uniform basic data set for long-term care to other States in Region V, evaluation of the feasibility and impact on quality of the use of indices of quality of care in nursing homes.

The research and development efforts focused on developing mechanisms and instruments for patient assessment to improve decision-making regarding placement, continuity and appropriateness of care, assessment of quality of care being provided; and assessment of the cost-effectiveness of alternative methods of care.

Through grants and contracts, studies were conducted in the broad areas of: (1) quality of care; (2) management information and data systems; and (3) alternatives in long-term care.

(A) RESEARCH AND DEVELOPMENT

Quality of Care

Research and demonstration efforts are continuing in the development and testing of mechanisms and instruments for patient assessment. The "Patient Classification for Long-Term Care—User's Manual," developed through a DLTC grant, is the basic tool for patient assessment being utilized in several grants. The Manual is essentially a set of descriptors that form a uniform terminology with which to assess the status of an individual at one or more points in time. This information about the individual can then be used in the decisionmaking process with regard to care-planning, placement, appropriateness of care, staffing, reimbursement, utilization and medical review. A grant to Harvard, Center for Community Health and Medical Care, now in its third year, has utilized the Manual to assess the status of Nursing home residents at several intervals of time. To date approximately 4,000 assessments and reassessments have been made on the resident population in nine nursing homes. A supplemental portion of this grant has brought together the four research groups who developed the Manual together with providers, health department representatives, and those concerned with rate setting, cost accounting, and standard setting from the four States (Maryland, Massachusetts, Michigan, and New York) represented by the research groups. The interest generated through the workshops attended by these groups has led to widespread use of the Manual as a decisionmaking tool with wide ramifications for the long-term care field.

The same basic descriptors are being utilized in a grant with Johns Hopkins University in which patient profiles are delineated through the assessment process, care plans are formulated based on the needs of the patients, and guidelines are developed for review of the appropriateness and extent of services provided. Ultimately, resource patterns for staffing as well as service needs will be defined, based on the patient-population's needs. In addition to the basic descriptors, additional psychosocial and environmental factors are included in the assessment instrument. For this project, the sample population includes persons receiving home care as well as nursing home residents.

Another Division grant is designed to carry out the planning and development activities necessary to research the variables related to the outcomes of nursing home care (length of institutional stay, mortality rate, place to which discharged, change in functional status, change in mental status and consumer satisfaction). Staffing patterns, costs, employee and administrator attitudes, environmental and structural variables and ownership-control status, among other variables will be considered for relationship to the outcome measures. The acceptability of the research protocol and design to nursing home administrators is assured through a close coordinating effort.

The instruments and quality construct for a quality evaluation system were developed through a contract with the Rush-Presbyterian-St. Luke's Medical Center in Chicago. This system is designed to be an effective tool for use in the regulatory mode by surveyors to ascertain the quality of care provided by a given institution based on the needs of its patient population. For testing in a regulatory mode, the quality evaluation system is now being incorporated into the Long-Term Care Automated System of the Illinois Department of Public Health and will be utilized in 100 long-term care facilities by the State surveyors. Should this quality module be effective it will then be available for use in other state automated systems.

Through the contract mechanism, the DLTC is providing support for development of a realistic plan that will enable nursing homes to utilize community resources to meet the needs of in-patients or to plan for a patient's return to community living without interruption of his continuing care needs. There will be a documentation of the processes of planning, organizing and implementing the program to provide a foundation for future development and testing in other communities. Currently, work is progressing well in the survey of resources, identification of problems and solutions to these problems.

(B) MANAGEMENT INFORMATION AND DATA SYSTEMS

In 1974, projects went beyond simple data collection to an analysis of the usefulness of data to government and non-government agencies and providers. The contract with the State of Illinois provided technical assistance to 6 States (Minnesota, Wisconsin, Iowa, Maryland, Washington and Colorado) in assessing their long-term care data needs and adapting the Illinois system to priorities and resources. In addition, 6 other States were given an orientation to the system.

Information gained from these experiences with the resources, problems and priorities of 12 States is being analyzed to determine factors which must be considered in the development of official agency management information systems. Project staff are in touch with management information staff of the Social and Rehabilitation Service, Office of Nursing Home Affairs, and Social Security Administration so that information gained can promptly be used by the Inter-agency LTC-MIS Task Force.

The Iowa Hospital Association project has developed a management information system which has potential for use by facility staff and consultants to screen problems and identify areas where consultation and inservice education

are needed, as well as data which could be used for State medical review processes. It is also useful as a management tool to compare the performance of two facilities. It was not moved to a Statewide basis because the information about the data and its usefulness is well documented. Information on this project has been shared with the National Center for Health Statistics, Social and Rehabilitation Service Management Information Division and Division of Utilization Control, and the Office of Nursing Home Affairs staff.

In January 1974, grants were awarded to the American Nursing Home Association and American Association of Homes for the Aging for a cooperative study of a Cost Data Reporting System for Nursing Homes. The primary focus is the development of a system for analyzing the costs of long-term care according to patient characteristics and service departments in order to provide a sound basis for decisions by administrators, public policy makers, and purchasers of services. During the first year they have examined methods of utilizing consistently defined data and applying these methodologies to a representative set of delivery organizations to test usefulness to the administrator and government officials.

(C) ALTERNATIVES IN LONG-TERM CARE

Experiments under Public Law 92–603

Of all research activities relating to alternatives in long-term care, the experiments authorized in 1972 by P.L. 92–603 have provided the greatest challenge in implementation. Because of the widespread interest in the outcome and the innovative approach involved, a chronological report of events relative to this activity is provided.

I. *Legislative Authority*

Enacted October 30, 1972, Public Law 92–603 (Amendments to the Social Security Act of 1972), Section 222(b)(E) and (H), authorized the conduct of experiments and demonstrations "to determine whether coverage of intermediate care facility services and homemaker services would provide suitable alternatives to post-hospital benefits presently provided under Title XVIII of the Social Security Act" and "an experimental program to provide day care services—for individuals eligible to enroll in the supplemental medical insurance program established under Part B of Title XVIII and Title XIX of the Social Security Act—."

II. *Development of Proposal*

Responsibility was placed in the Bureau of Health Services Research (HRA), with developmental staff work, monitoring, and coordination with other government agencies carried out by the Division of Long-Term Care.

In March 1973, a Coordinating and Technical Work Group was created. Staff included representatives of Bureau of Health Services Research, Office of Nursing Home Affairs, Bureau of Health Insurance, Administration on Aging, Medical Services Administration, and National Institutes of Mental Health. Meetings were held to discuss basic concepts and develop draft proposals.

Working definitions and state-of-the-art papers on Intermediate Care, Homemaker Care, and Day Care were developed, and Draft Regulations on Day Care were prepared. Throughout the developmental period, the Coordinating and Technical Work Group was utilized to perform specific tasks and to react to various drafts of the proposal.

The proposal was completed and a Request for Proposal was published in the *Commerce Business Daily* on April 12, 1974, with a deadline of May 21, 1974, for receipt of proposals by the Contracts Office.

III. *Summary of Demonstration Projects*

***Objectives:* The specific objectives of these contracts called for the contractor to demonstrate, experimentally, provision of day care services and/or homemaker services in order to: (1) determine the cost of providing each of these services; (2) compare the cost of providing the new services and the currently covered services (Skilled Nursing Facility Care and Home Health Services); and (3) determine and compare the extent to which the new services (as defined) will enable an eligible individual to reach and maintain his highest level of performance or will prevent or retard institutionalization as compared to the effectiveness of benefits currently provided.**

Methodology: Methodology included the identification of target population for the new services; developing sources of referral of patients to the demonstration projects; acceptance of potential patients in the demonstrations; initial patient assessment and developing of care plan; randomization of demonstration population into a control and experimental group; and periodic reassessments of both experimental and control patients.

Expected Results: Valuable information should be obtained on the utilization by patients of the new optional services and the cost of not only providing the covered Medicare services, but also the new optional services to the experimental group of patients, plus out-of-pocket costs and other third party reimbursements for health care received by the experimental group. The contribution of multidisciplinary patient assessment and care planning with projected outcomes also should provide a great deal of information in relation to testing the patient assessment material.

IV. *Widespread Interest in Proposal*

More than 125 requests were made for placement on the Selected Bidders List for the proposal. Significantly, however, only 22 proposals were actually received. One reason for the limited response might be the requirement for the development of a sophisticated research plan involving application of an assessment instrument by a multidisciplined team, the use of experimental and control groups, and the need to have in place specific innovative service programs. Frequently, an insurmountable hurdle was that the required service activity was not already in place, or the innovative service might have been in place but because the sponsoring organization was more service-oriented than research-oriented, it either did not make the effort to apply, or submitted a plan that was strong in terms of services but weak in terms of research thrust. Conversely, those organizations that were primarily concerned with research frequently were not sufficiently oriented on the fine points of service delivery for these innovative activities.

V. *Evaluation of Proposals*

The proposals were evaluated in four categories: Intermediate Care Facility Services, Homemaker Services, and Day Care Services; Homemaker and Day Care Services; Homemaker Services; and Day Care Services. An Evaluation Panel, chaired by the Director of the DLTC and staffed by five Federal and five non-Federal specialists, evaluated the demonstration project proposals.

VI. *Awards Made*

The following is a listing of contract awards by category:

Day Care and Homemaker Services.—San Francisco Home Health Service, San Francisco, Calif.; Lexington-Fayette County Health Department, Lexington, Ky.

Homemaker Services.—Inter-City Home Health Association, Los Angeles, Calif.; Homemaker-Home Health Aide Services of Rhode Island, Providence, R.I.

Day Care.—Burke Rehabilitation Center, White Plains, N.Y.; St. Camillus Day Care Program, Syracuse, N.Y.

VII. *Evaluation Contract*

A separate contract with the Medicus Systems Corporation, Chicago, Ill., made by the Bureau's Division of Health Services Evaluation (DHSE) will evaluate the experimental demonstrations with respect to the achievement of project goals and objectives. The evaluation will isolate reliable from unreliable findings so that policy implications can be drawn with respect to expanding Medicare/Medicaid benefits to include Day Care and Homemaker services. This contract is being monitored by staff from DHSE, working in close coordination with the DLTC Project Officer of the six demonstration projects.

VIII. *Action since July 1, 1974*

On September 9 and 10, the six contractors accompanied by the agency's fiscal officers met with representatives of HRA (Division of Long-Term Care and Division of Health Services Evaluation) and representatives of Social Security Administration (Bureau of Health Insurance). The training was provided by SSA (Division of Direct Reimbursement) and was focused on billing and reimbursement for the new services to be provided by the Demonstration Contractors as well as other fiscal management responsibilities.

A four-day orientation and training program was held in mid-November for the Contractors, the Project Directors and the Research Teams, in which training was provided in the use of the Patient Assessment Instruments and the Evaluation Plan.

Unexpected delays have been encountered, but it is anticipated that in March 1975, the first patient referrals will be made to the demonstrations. Eligible referrals will be assessed using the Patient Assessment Instruments and randomized into control and experimental groups. Each patient will be followed for one year with reassessment of health status at quarterly intervals.

The final report of the analysis of data (fiscal and patient status) is expected to be ready for dissemination in the fall of 1976.

"Home Care: An Alternative to Institutionalization"—This project has been implemented by the Executive Office of Elder Affairs, Boston, Massachusetts, and is in its third and final year. The project proposes to demonstrate that a community-based home care program of coordinated health, social and other support services, drawing on the same sources of funds now used to pay for institutionalization (Medicaid) can provide a more cost-effective option for the care of the elderly. The National Center for Health Services Research and Development (later the Bureau of Health Services Research) and Administration on Aging have joint-funded the project since its inception.

"Housing and Health Care Paths of Dependent Elderly"—Implemeted by the Center for Research in Social Behavior, University of Missouri, the project proposes to demonstrate that personal and social circumstances attending entry into full care facilities provide a content within which the quality of care will be in part defined. The supplemental proposal plans to increase the size of the sample of expanded households and boarding homes (operations, their residents and residents' families) and to add a small town sample of expanded families and of boarding/nursing home residents. This project was funded by Administration on Aging and the supplement by the Bureau of Health Services Research.

"Evaluation of Alternative Systems of Services for Aged at High Risk for Institutionalization"—Implemented by Duke University Medical Center, Durham, N.C., this project is in the third and last year. It is designed to: (1) develop improved evaluation procedures to assess the impact of intervention on impaired elderly persons; (2) study the differential outcome of several alternative service delivery systems; (3) obtain accurate estimates of the true incidence of significant impairments among elderly persons, impairments which place them at high risk for institutional care; and (4) deliver in the process of achieving the first three goals, actual clinical services to impaired elderly persons. The plan for fiscal year 1975 is to continue testing the instrument for validity and reliability, continue indepth study of the sample assessed one year ago, and determine costs of services.

As a result of two subcontracts, funded by Social and Rehabilitation Service, the instrument is being revised so that long-term candidates of all ages can have their needs assessed, in preparation for mounting a nationwide survey of a statistically valid sample of people in need of long-term care.

This project has been joint-funded since its inception by Administration on Aging, National Center for Health Services Research and Development (later known as the Bureau of Health Services Research), and Social and Rehabilitation Service.

"National Center for Aging and Black Aged"—Carried out by the National Caucus of Black Aged, Inc., the project supports establishment of a Center to provide a comprehensive program of coordination, communication, information, and consultative services to meet the need for assistance in improving meaningful policies and programs involving aged blacks.

The project is in its second year and has been joint-funded by Administration on Aging and the Bureau of Health Services Research.

"Alternatives to Institutionalization for the Aged"—Implemented by Colorado Department of Institutions, Denver, Colo., the primary aim of this project is to improve the quality of life of elderly inpatients in the Fort Logan Mental Health Center through placement in specialized living arrangements (artificial family or boarding home program), as alternatives to institutional care at a cost lower than that of nursing home care or inpatient psychiatric hospitalization. Evaluation of the effectiveness of this program from the standpoint of quality of life and costs is currently underway. This project is in its third and final year and has been joint-funded by Administration on Aging and the Bureau of Health Services Research.

(D) TRAINING AND TECHNICAL ASSISTANCE

Responsibility for directing Federal resources toward short-term training of personnel employed in long-term care facilities continues in the Division of Long-Term Care (Provider Improvement Branch). Since the inception of provider training activities with the Administration's Nursing Home Initiatives of 1971, there has been continual growth of training opportunities through a variety of strategies. With an appropriation of $1.8 million each year since 1971, the number of training opportunities supported has reached approximately 78,000 professional and para-professional long-term health care personnel as of December 31, 1974.

In 1974, to further the Department's efforts toward upgrading the quality of care in the nation's nursing homes by improving the skills of those responsible for providing that care, 16 training contracts totaling almost $1.3 million were awarded.

Contracts for statewide training programs were awarded to the Texas Nursing Home Association, Weber State College (Utah), the Wyoming Health Training Network and the University of Maine for the instruction of nurse aides employed in long-term care facilities in rural areas of these States.

Contracts with national organizations included:

American Medical Association for the nationwide training of Medical Directors in skilled nursing facilities. This project is responsive to the new legislative requirements for medical directors in skilled nursing facilities, which are mandatory by December 1975.

American Dietetic Association for initiating training, offered by the Association, through a series of nationwide seminars and workshops for at least 3,000 dietitians and other food service personnel employed in long-term care facilities.

American Medical Record Association to provide a national training system for Medical Record Consultants employed by long-term care facilities.

In 1973, six Regional Training Centers were created to train multidisciplinary teams from long-term care facilities within the geographic area, with the focus on combined on-the-job and didactic training. These included New England Rehabilitation Center, Woburn, Mass.; Burke Rehabilitation Center, White Plains, N.Y.; Philadelphia Geriatric Center, Philadelphia, Pa.; Presbyterian Village, Dallas, Tex.; Beth Israel Hospital and Geriatric Center, Denver, Colo.; and Garden Crest Convalescent Hospital, Los Angeles, Calif.

In 1974, each of the centers was provided continuation funds to develop and implement new courses, further develop evaluation activities, expand the number of specialty seminars, and establish a program to train educational designees to organize and conduct inservice training programs for nursing home personnel in their own facilities and communities. This innovative approach to long-term care training is experiencing general success, and ongoing evaluation of the programs has led to modifications which are responsive to the varying regional and State needs. Also in 1974, three additional centers were funded. They are: Sister Kenny Institute, Minneapolis, Minn.; Swope Ridge Health Care Center, Kansas City, Mo.; and L. C. Foss, Sunset Home, Seattle, Wash. A training center to serve Region IV is planned for 1975, thus completing the Nationwide Long-Term Education System.

A contract was also awarded to the Capital Systems Group, Inc., Rockville, Md., to develop a Media Center that will serve as a source of published material, audiovisual aids, training curricula and research documents related to gerontology as well as to the health, environmental and psychosocial aspects of long-term care. This center will be for the use of contractors, students, researchers and others.

Two of the contracts that called for development of training aids and materials were completed in 1974. The products delivered to the government included sound-slide programs for use in long-term care facility inservice training programs. The product developed by the Robert J. Brady Company, Bowie, Md., is for general staff development, and the product developed by the American Hospital Association is for multidisciplinary training in Reality Orientation. Both training programs are currently in production and will be available Spring of 1975.

As a part of the evaluation of the Activities Coordinators Training Project, conducted by the American Nursing Home Association, curriculum materials and revision of the text of the "Activity Supervisor's Guide" have been undertaken and the manuscripts have been delivered. They will be published in the coming year and used in future training efforts.

The American Nurses Association and National Association of Social Workers contracts for nationwide training programs were completed in 1974. Critical needs for additional training assistance for both nurse consultants and social work consultants were identified, and Division of Long-Term is discussing the development of consultation guides by each organization.

Evaluation

The effectiveness of the training is subject to ongoing evaluation in an effort to determine which of the approaches are the most cost effective and to gain knowledge on the utilization, appropriateness, and effectiveness of educational methodologies utilized in the various strategies.

An evaluation of the entire long-term care training effort is being conducted under contract with J^2–B^2 Consultants, Inc., Los Angeles, Calif. (See Section on Division of Health Services Evaluation for additional details.)

Regional Office Long-Term Care Education Coordinators

Another approach to training provider personnel has been through the Regional Office Long-Term Care Education Coordinators. The Regional Coordinator in each DHEW Region meets with groups from within that Region to plan strategies identifying and meeting specific training needs and directing available resources toward meeting needs, while at the same time helping to maximize the utilization of local resources and local expertise. The Regional Office Long Term Care Education Coordinators have been very effective in maximizing the national training contracts through their work with State affiliates of the national professional organizations.

Approximately 20 percent of fiscal year 1973 and 1974 funds were earmarked for use by the Regional Offices, enabling them to be responsive to State and local short-term training needs.

During 1974, with the creation of the Regional Offices of Long-Term Care Standards Enforcement, eight of the ten Long-Term Care Education Coordinators were transferred to this new office from PHS.

1975 Projections

Plans for a continuation of the training effort in 1975 call for activities to be centered in those general areas being brought to focus as a result of new Skilled Nursing Facility and Intermediate Care Facility regulations. Data supplied from training program evaluations, provider and consumer organizations, and professional staff judgment are used in establishing priorities.

Areas of special emphasis during 1975 include: rehabilitation nursing; medical director training; medical record clerk training; training of long-term care personnel in patient and family education; multidisciplinary training drug therapy; and nursing home administrator training. Continuation and strengthening of the National Long-Term Care Education System (Regional Training Centers) is a top priority for 1975.

(E) WORKSHOPS AND CONFERENCES SPONSORED BY DIVISION OF LONG-TERM CARE

In 1974, three workshops were sponsored by DLTC, and all were attended by representatives of HRA, HSA, ONHA, and other DHEW agencies involved with long-term care and aging.

1. The *Workshop on Innovative Approaches to Alternatives in Long-Term Care* concerned itself with cost-effective as well as consumer-acceptable approaches that bear further study.

2. The *Workshop on Death and Dying* was directed at an investigation of the role of long-term care personnel in working with the terminally ill patient and his family, and a discussion of the training needs for professional and paraprofessional personnel in this area.

3. A working group to develop plans for the first *National Conference on Day Care* was held in October. Federal members included representatives from DLTC, DHSE and DHSRA of BHSR, MSA, SSA, AoA, BQA, NIMH and OPC. Non-Federal participants included representatives of the Medicaid programs of Massachusetts and New York, day care researchers, a member of the Long-Term Care for the Elderly Research Review and Advisory Committee, and a Consultant on Long-Term Care, Office of the Secretary.

The following workshops are planned for 1975:

1. February 25–26: A *Workshop on Geriatric Aural Rehabilitation an Emerging Program.*—Such a conference could serve as a vehicle for the pooling of available

knowledge of new developments in this field, and could help to create an effective strategy designed to apply new knowledge in meeting recognized needs.

2. April 29–30: A *Workshop on Short-Term Training* to bring together DHEW staff and American Nursing Home Association State Education Directors for sharing information and discussing future needs and possible strategies.

3. March: A conference with representatives of the Association of State and Territorial Directors of Nursing (an affiliate of ASTHO) to plan the National Strategy for implementing rehabilitation nurse training.

4. Spring 1975: A grant to American Association of Homes for the Aged and the American Nursing Homes Association calls for development of a system for analyzing costs of long-term care based on patient characteristics and uniform service cost elements. As part of this grant, two institutes will be sponsored by the two organizations to explain the system and results of preliminary tests to representatives of government and industry.

5. June: A Workshop on Day Care for developing Day Care programs to provide an opportunity for a sharing of experiences and a discussion of future research needs. In addition to Federal participants, the *Planning Workshop for the National Conference on Day Care* also included representatives of New York, Massachusetts, and Maryland Medicaid programs.

Collaborative Activities with the Office of Nursing Home Affairs

Division of Long-Term Care staff has a strong ongoing working relationship with ONHA. In preparation for the ONHA Nursing Home Survey, several DLTC staff members chaired and/or participated in task forces to help develop guidelines, training materials and innovative approaches utilized in the campaign. DLTC staff made a contribution in the development of the survey instruments and also served as faculty for training sessions for the survey teams. Two staff members were released for 60 days to actively participate in the field surveys.

The DLTC Director serves as a permanent member of the ONHA Interagency Advisory Group and the Interagency Task Force on Short-Term Training. The latter group has been formed to consider the special short-term training needs that will arise as a result of publication of new regulations relating to the skilled nursing facilities.

The DLTC Deputy Director participates in the Work Group of the Interdepartmental Task Force on Aging, the total Interdepartmental Task Force on Aging, and the Interagency Committee on Prevention.

Collaborative Activities within DHEW

A presentation was made by the Director, Division of Long-Term Care, to the National Steering Committee of the Regional Medical Program Coordinators on "Training in Life Safety for the Long-Term Patient." Division of Long-Term Care staff assisted the Regional Medical Program Service in preparation of guidelines for the Arthritis grant program, orientation of Regional Medical Program Service staff in Long-Term Care, and actively participated in review of grant applications.

Division of Long-Term Care is represented on the National Institute of Mental Health Interagency Liaison Group on Mental Health Aspects of Medicare and Medicaid and the Interagency Work Group on Technical Assistance regarding Intermediate Care Facilities for the Mentally Retarded.

Staff of the Division of Long Term Care are currently serving on two National Center for Health Services Research Task Forces: the Quality Task Force and the Emergency Medical Care Task Force.

Collaborative Activities with Other Agencies

The Division of Long-Term Care Director presented a paper on "Death and the Coping Mechanism of the Professional" at the Twelfth Annual Clinical Symposium conducted by the Lackland Air Force Base in Texas.

The Deputy Director, Division of Long-Term Care, continued to serve as the Health, Education, and Welfare representative to the Veterans Administration to plan for and actively participate in the second in a series of regional workshops on "Caring Environments for the Aged Patient."

The Veterans Administration also produced two teaching films, "Cardiopathy of the Aged" and "Dermatology Problems of the Aged," based on monographs in the Bureau of Health Services Research publication "Clinical Aspects of Aging."

At the request of the Department of Commerce, the Deputy Director has continued to speak on "Health in the Later Years" at their annual Pre-retirement Seminars.

Liaison has been established with Department of Health, Education, and Welfare, Office of Education, Division of Manpower Development and Training, in relation to common concerns on training ancillary health personnel in long-term care.

DLTC Participation with Non-Governmental Organizations and Agencies

1. The Director, Division of Long-Term Care, serves on the Editorial Advisory Committee of the American Medical Association's newsletter *Perspectives in Long-Term Care.*

2. Division of Long-Term Care staff have served as keynote speakers on problems relating to research and provider improvement activities at national and state organizations and agencies, and have participated in the planning and conduct of workshops and seminars sponsored by Federal, professional, and voluntary organizations throughout the nation.

3. At the annual meeting of the American Public Health Association, the Division of Long-Term Care Director presented a paper entitled "Multiple Jeopardy: The Special Problems of Being Old, Poor, and a Minority Member."

3. DIVISION OF HEALTH SERVICES

(a) EVALUATION

"Medicaid Analysis of Utilization, Cost, and Quality"

There is a definite need to measure, assess, and evaluate the utilization patterns, costs, and quality across various State Medicaid plans. No data are currently available which will permit a comparative analysis of the Medicaid program in a comprehensive manner. For the Federal/State program spending in excess of $9 million annually, there is a critical need to understand some of the reasons.

Data from three States will be analyzed. The three States will be selected from an eligible listing of ten States. Data tapes on the eligibles and claims data will be obtained, reformatted, and analyzed to address each of the evaulation objectives.

The study will be used to provide information on the utilization and costs of providing care to poor and near poor individuals through the Medicaid program. It will also provide insights into the type of providers involved in the program and their qualification as compared to the non-poor population. This information will be important for assessing the potential levels under National Health Insurance, on utilization, costs, and resource distribution in different areas.

"Followup Health Surveys for Evaluating Neighborhood Health Centers"

It has been about 5 or 6 years since the Neighborhood Health Center projects were established. The initial evaluation agenda included plans to conduct baseline and followup health surveys to measure program impact. So far, identical baseline surveys have been conducted in a number of NHC service areas during the period between 1968 and 1971.

The issue for policy is to assess how these new delivery systems may have influenced utilization patterns, care of persons with chronic conditions, and what impact they may have had on hospital and disability days as well as other types of care including long-term care.

Followup household interviews will be conducted by a qualified survey organization, using a standard area probability sampling technique. There are inherent problems in relating two cross-sectional surveys 5–6 years apart, but by use of major control variables and "control" groups (users of other providers), it is expected that the effect of NHC projects on health behavior in the area can be described.

"Design of an Evaluation of Training Programs for Staff of Long-Term Care Institutions"

The objectives of the study are to determine the effectiveness and efficiency of the various types of short-term training of personnel providing services and care in long-term care facilities and to recommend the most appropriate educational strategies and methodologies to improve skills, attitudes, and performance of long-term care provider personnel. The educational efforts to be evaluated include: (1) programs contracted for by universities, facility organizations, state health departments; (2) programs contracted for by national organizations such as AMA, National League for Nursing, etc.; and (3) programs contracted for known as the Regional Long-Term Care Training Centers. The Division of Long-Term Care actively participates in the conduct of this project.

"Program Evaluation Alternatives in Long-Term Care—Alternative Modes of Adult Day Care"

Day Care for the elderly has been interpreted in many ways, ranging from a level of care provided in centers offering only a pleasant, supervised, comfortable environment, with some diversion, to provision of rehabilitation and restorative services aimed at enabling the individual to return to independent living in the community. Many programs that should properly be classified as Senior Centers call their programs "Day Care." The study is to develop narrative and quantitative comparisons among 10 centers (4 federally funded time-limited research demonstrations and 6 ongoing operational centers) to determine what needs to be known in quantitative terms, and how it can be uniformly and consistently obtained, in order to enable resource allocators to compare alternative configurations of day care services. The Division of Long-Term Care actively participates in the conduct of this project.

(b) QUALITY RESEARCH

"Community Care: The Chronic Disease Service Module" is a program carried out by Dr. Sidney Katz of Michigan State University. This project will test the premise that the use of specially-trained assistants will allow greatly expanded and improved delivery of care by physicians to chronically-ill patients. To this end, the project has developed and trained new chronic care assistants to serve in modular teams (2 assistants, 1/2 physician, 1/2 PHN/SW) that can be attached to various institutional settings (hospital, ambulatory clinic, HMO, etc.).

Using randomly-assigned stratified test, monitoring and control groups, the project will assess the differential outcomes (functional status, clinical observations, etc.) and economic impact (relative delivery costs, patient costs, incurred institutional costs, etc.) of the program vs. the usual fractured care available to chronic patients. Assessments will also be made of organizational viability, professional acceptability, reimbursement issues, patient satisfaction, legal limitations and other parameters determining wide-scale feasibility.

"Clinical and Cost Benefits of the Evaluation Unit" is a 2-year program carried out by the Genessee Regional Health Planning Council, Inc., Rochester, N.Y. Available data indicate an extensive degree of inappropriate use of long-term care facilities and services for chronically ill and aging persons, usually at higher and more expensive levels of care than this Evaluation and Placement Unit have shown that an expert comprehensive medical-nursing-special evaluation and placement service can achieve improved appropriateness of placement (as judged independently) including more frequent placement at less intensive levels of care and maintenance of more persons at home with supporting services. Preliminary findings indicate resultant important savings in the costs of long-term care.

The present project is designed to determine more precisely the benefits of this new service, in terms of health outcomes and costs, through a comparison of the results of evaluation and placement by this Unit with the results of the usual placement procedures of a county Medicaid nursing home office which relies largely on written information to decide about long-term placements.

Several recent efforts by *Experimental Medical Care Review Organizations* (EMCRO's) have been directed to the development of quality assessment mechanisms for the long-term care sector. The Georgia EMCRO developed a nursing home audit and review mechanism intended to review the quality of care, assist with the determinations of appropriate levels of care, and document changes in patient status overtime. The Mississippi EMCRO is attempting to develop a similar mechanism. In New Mexico, an evaluation is now underway on the impact of a Medicaid claims review mechanism for nursing home care.

Staff of the Division of Health Services Quality Research have worked with representatives of the Bureau of Quality Assurance, HSA, to assure that the results of relevant research projects are considered as guidelines for PSRO review of long-term care are developed. Several of the above-cited projects have helped influence the current guideline development work.

(c) SYSTEMS DESIGN AND DEVELOPMENT

Division of Long-Term Care staff is working in close collaboration with DHSDD in each of the following projects.

"*A Model Services Delivery System for the Aging*" is being developed by the Mon Valley Health and Welfare Council, Inc., Monessen, Pa. This calls for creation of a demonstration model for the systematized delivery of comprehensive services for the aging as an extension of the Mon Valley Experimental Health Services Delivery System activities.

"*Day Hospital Service Rehabilitation Medicine*" is an innovative program conducted by Albert Einstein College of Medicine in New York City, Bronx, N.Y. This 3-year study is designed to determine the feasibility of operating a day hospital service in the Department of Rehabilitation Medicine of a large municipal hospital serving a primarily disadvantaged population. The study population is 200 day hospitals and 200 hospitalized patients, seriously disabled adults, eligible for Medicare and Medicaid, residing in the hospital district serviced by the Bronx Municipal Hospital Center. The Division of Health Services Evaluation will conduct an evaluation along with other similar demonstrations as described under the activities of section 222 of P.L. 92–603. The overall evaluation will be in addition to the internal evaluation being conducted by the project. The overall evaluation is necessary because of the need for an independent comparative review.

(d) RESEARCH AND ANALYSIS

"*Study of Aged Applicants to a Long-Term Care Facility.*" Sylvia R. Sherwood, Ph.D., Hebrew Rehabilitation Center for Aged, Roslindale, Massachusetts. This recently completed research project had three objectives:

1. To assess the impact of diagnostic and therapeutic health care services on a group of aged persons who had applied for admission to a long-term care facility. The purpose of the intervention was to reduce the need for institutionalization and improve client well-being.
2. To develop and standardize instruments to measure the health and well-being of aged persons.
3. To gain a better understanding of the needs of aged persons and of the aging process.

The objectives of the research were reached. The intervention program was shown to have very positive benefits, both in reducing mortality and the need for institutionalization; measuring instruments were tested and refined; some clear-cut conclusions were drawn regarding the value of specific intervention techniques.

"*Review and Analysis of Long-Term Care Literature: Implications for Planning, Action, and Research.*" Sylvia R. Sherwood, Ph. D., Hebrew Rehabilitation Center for Aged. This publication, a review of long-term care literature and knowledge, comprises thirteen chapters dealing with major facets of the long-term care area in the context of its usefulness for planning, action, and further research authored by prominent authorities in the field. It is scheduled for publication in February 1975 and is regarded as a major source book in long-term care.

"*Systems of Reimbursement for Long-Term Care Services.*" This contract, now in its initial phase, will survey reimbursement practices in 50 States, convene experts for discussions, analyze findings and develop a model for the reimbursement of long-term care services which will most economically provide the necessary quality of services for long-term care patients.

"*The Nursing Home Simulation Model: A Policy Tool for Long-Term Care.*" *Medicus Systems Corporation and the Illinois Department of Public Health.* Working in close collaboration with the Division of Long-Term Care, this contract was developed by DHSRA largely in response to the concerns of Congress and health professionals that regulations governing the staffing and services provided in nursing homes be adequate for the well-being of residents and that costs of care be controlled to the extent possible, consonant with well-being.

The model was developed to help health planners, operators, and standards and licensure agencies evaluate the effectiveness and efficiency of alternatively configured long-term care facilities providing different types of care to a variety of patient populations. The Nursing Home Simulation Model provides the capability of determining whether a given set of nursing resources is sufficient to provide a defined level of care to a particular patient population. The model has the additional capability of evaluating the cost effectiveness of meeting the nursing care requirements of residents under alternative staffing configurations and systems for the delivery of care.

NEW PUBLICATIONS FROM BHSR

The "Patient Classification for Long-Term Care—User's Manual," developed under a National Center Health Services Research and Development research grant, was published in December 1973 and during 1974 the publication has been given wide dissemination, not only to researchers but to providers of services as well. The Manual is a tool for improving the care of patients with chronic illness through systematizing the information base upon which the providers and planners of care made decisions. The Commission on Chronic Illness (1949–1956) had recommended the development of a terminology for use in evaluating needs of patients in order to provide appropriate treatment for individual patients and at the same time, make better and more economical use of resources available. This published work is the outgrowth of many years of Public Health Service conferences, discussions, individual effort and finally a collaborative research effort directed toward this goal. Further research is necessary to identify additional appropriate descriptors in the psychosocial and environmental areas. This publication is available from the Office of Scientific and Technical Information, Bureau of Health Services Research, Room 15–75, Parklawn Building, DHEW Publication No. HRA 74–3107.

"Homemaker/Home Health Aide Services in the United States," by Brahna Trager has been printed and is available from Government Printing Office as DHEW Publication HSM 73–6407. This book is a unique contribution to the health care field because for the first time it provides a complete analysis of the contribution and the homemaker/home health aide can make to patient care as well as the broad area of home health agency operation, both in the U.S. and abroad. Staff of the Division of Long-Term Care have contributed to the development of the book over the years through contract activities and technical assistance.

"Preliminary Analysis of Select Geriatric Day Care Programs," developed for the Division of Long-Term Care by the Levindale Geriatric Research Center in Baltimore, Maryland. The pamphlet is available upon request from the Division of Long-Term Care.

J. FOOD AND DRUG ADMINISTRATION

Laws enforced by the Food and Drug Administration (FDA) are designed to protect the health, safety, and pocketbooks of all consumers regardless of age. But this protection is particularly important to the elderly consumer, who has interests and special problems peculiar to this age group. During 1974 there were many events and actions which illustrate the significance of FDA's protection of the elderly.

PROTECTING THE HEART PATIENT

The millions who have heart ailments were special beneficiaries of FDA actions involving drugs and devices. Stronger controls were set up to insure uniform potency of the critically important heart drugs digoxin and digitoxin. On January 22, 1974, a regulation "Digoxin Products for Oral Use: Conditions for Marketing" was published. This order converts a previous voluntary testing and certification program into a mandatory system. The order:

—Declares all oral digoxin products to be "new drugs."

—Requires submission of an Abbreviated New Drug Application, including results of bioavailability tests, for all oral digoxin products.

—Requires batch-by-batch testing and certification by FDA until the manufacturer has demonstrated that he complies with all of the requirements of the FDA regulations.

—Requires recall of any batch of digoxin tablets, marketed prior to issuance of this regulation, found to fail specified tests.

Thirty-five manufacturers are involved in this program. Since its initiation, 31 percent of the currently marketed batches of digoxin failed to meet FDA test standards. Recalls were initiated on all of these batches to remove them from the market.

"Bioavailability" and "Bioequivalence"

"Bioavailability" and "bioequivalence" have become important new terms in the FDA drug lexicon.

It has been found in several instances that chemically identical drugs—drugs meeting identical official standards and labeled for the same medical indications—were not bioequivalent and in some instances resulted in therapeutic failures. Digoxin is an important example—peak blood concentrations after a single dose varied among products of four manufacturers as much as sevenfold and nonuniformity was demonstrated even within the same brand. In consequence medication refills for a heart patient could cause either inadequate therapeutic response or toxic effects. As a result of these findings a testing and certification program at the National Center for Drug Analysis, St. Louis, Missouri, is one of several important FDA activities to insure uniform dosage with digoxin products.

Demonstrable instances of therapeutic inequivalence are difficult to identify and the possibility remains that other failures in bioavailability are going undetected. Proposed regulations are now being drafted to establish procedures to assure the *bioequivalency* of drug products that contain the same active ingredients and are intended to produce the same therapeutic effect, and to be used interchangeably. Such controls will in some instances help to make it possible for consumers to make substantial savings in their drug purchases.

"Maximum Allowable Cost"

Since economic as well as therapeutic considerations are involved in bioequivalency problems the Department of Health, Education, and Welfare has proposed "Maximum Allowable Costs" (MAC) regulations to control drug reimbursement payments under the Medicare and Medicaid programs. It is estimated that savings from 22 to 36 percent—around $90 million annually—would result from dispensing lower cost equivalent generic drug products. But are the competing brands of the same drug actually equivalent? To meet this concern the Departmental regulations require that FDA identify any situation where pending or anticipated regulatory action (including the establishment of bioavailability requirement) would warrant delaying the establishment of a MAC for a particular drug.

Cardiac Device Problems

The food and drug law also covers therapeutic devices, a very large, complex field including such diverse products as artificial hip joints, kidney dialysis machines and heart pacemakers.

Pacemaker devices are life-saving inventions for thousands of heart patients but any failure of such devices can be life threatening. Several problems with pacemakers required emergency action in 1974.

One company voluntarily recalled 159 imported heart pacemakers which had not been implanted from a lot of 444 distributed between March and June 1973. Problems caused by a design change required the recall. A total of 285 pacemakers from the lot had been implanted but were not recalled. The physicians in each of these cases were fully informed and replacements can be made if necessary. This is a minor surgical procedure, carried out routinely; for example, when batteries need to be replaced.

Another manufacturer recalled 165 implanted fixed-rate pacemakers because of problems with accelerated pacing. Four clinical high-rate pacing failures, including two patient deaths, had been reported with this model. All physicians receiving the devices were contacted personally, and letters were sent to alert all other consignees to the problem.

A survey of cardiac pacemaker manufacturers was completed in 1974. The objective was to develop information on which to base Good Manufacturing Practices regulations and standards. A review of pacemaker labeling resulted in advising four firms to provide additional information in labeling for physicians.

The Food and Drug Administration also completed a survey of heart valve manufacturers to identify problems associated with these devices. All U.S. heart valve manufacturers were inspected, covering all phases of manufacture, packaging, storage, and handling up to the time of implantation. Visits were also made to 27 hospitals where heart valves are implanted. Survey results indicate that the handling of prosthetic heart valves in hospitals is as critical as manufacturing quality control. The primary requirements for materials and design are strength, wearing ability (resistance to corrosion and biodegradation), and bio-compatibility (not causing blood cell destruction or blood clots).

STRONGER CONTROLS FOR DEVICES AND DIAGNOSTIC PRODUCTS

Creation of a new Bureau of Medical Devices and Diagnostic Products was approved by the Department of Health, Education, and Welfare effective February 7, 1974.

Many diagnostic products are medical devices, or have device components; thus, there is a relationship between these categories of health products. They constitute a large and rapidly growing segment of the health products industry. In 1971 it was estimated that total retail sales of medical devices was more than $3 billion, and likely to double in the next 10 years.

Because the technology of the field is highly specialized the kinds of regulation needed to protect the public from unsafe or ineffective products must also be specialized. Legislation establishing appropriate systems of control for different categories of products and materials has been developed and its early enactment is expected.

PROTECTING ARTHRITICS

A public warning, and total recall of two newly introduced arthritis drugs, were required because users could receive a serious toxic overdosage of salicylates. The products, "Aspirin Free Arthritis Pain Formula," and "Saloxium Analgesic/Anti-Inflammatory Tablets" were both made by Whitehall Laboratories, New York.

Because the active ingredient "salsalate" converts to sodium salicylate in the body, FDA was concerned that many users would be misled by the labeling of both drugs as "aspirin free" and take them along with aspirin or other salicylate drugs. This could be especially dangerous to those who have internal bleeding tendencies or who are receiving anticoagulent drugs. It was estimated that around $1 million worth of the products were involved in the recall.

FDA learned of the drug hazard through a complaint by a professor at the State University of New York at Buffalo and through a Midland, Pennsylvania pharmacist who alerted the agency through the FDA Community Pharmacists.

A public warning was issued June 1 against use of four imported Chinese herbal medicines from Taiwan labeled for back and leg pain. Each product contained the potent and potentially dangerous drug phenylbutazone. The death of one person and three cases of agranulocytosis, a serious blood disorder, prompted the warning. All four patients had been taking one or more of the medications.

Ordinarily Chinese herbal products are harmless and have no scientifically substantiated therapeutic value. The potent anti-flammatory drug is available in the U.S. only by prescription and should be used under close medical supervision.

UNPROVEN CANCER "CURES"

The promotion of unproven methods for treating cancer continues to threaten the lives of people who could be treated successfully by methods known to be effective. The temptation to try an unproven remedy can be very strong. Generally it involves going outside the United States, particularly to Mexico, where there is no requirement that effectiveness be proved scientifically before a drug is put on the market.

Such an unproven drug is Laetrile, also known as amygdalin a substance derived from apricot kernels. It is the principal drug administered for cancer in the Mexican border clinics. The drug was also marketed through health food stores in the United States under the names Aprikern and Bee-Seventeen. A preliminary injunction to stop the distribution of these products has been consented to by the manufacturer in the Federal Court at San Francisco.

A summary of information on Laetrile, from the FDA files, has been issued as an *FDA Consumer Memo*. This is available free upon request. Text of the memo is given as an appendix to this report.[1]

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[1] Retained in committee files.

CONSUMER EDUCATION ON DRUGS

The package insert in prescription drug products is the most important vehicle for communicating drug information to physicians. Much effort is put into making these "official brochures" accurate and complete, so the physician can depend on them.

Consumer education on the use of drugs is also needed to assure safe and effective treatment, especially with over-the-counter drugs. A mass media campaign launched in September 1974 has as its theme: *"Read the label. Don't take non-prescription medicines for granted. Take them with care."* Television and radio spots conveying this message also warned the public that overuse of OTC drugs can aggravate symptoms or hide a condition requiring a physician's attention. The broadcast messages are being widely used and several national magazines have requested plates for a printed advertisement using the same material.

FOOD PROTECTION

High over-all quality and continuous change are the two main characteristics of the American food supply. Food technology and the private enterprise system have revolutionized the food life style of the American people. Consumers collaborate in the process by providing an eager market for work-saving "convenience" foods of all kinds. But along with the new products and technology have come new problems of food safety and questions as to the nutritional adequacy of the changing American diet.

Actually, this is not a new situation, but one which has grown rapidly in complexity and importance. What *is* new is the FDA's planned efforts to cope with today's food problems.

The Federal Food, Drug, and Cosmetic Act makes industry responsible for food purity and safety. The FDA checks only a minute fraction of the total supply. Its role is to motivate compliance; not to inspect the product. The consumer's best hope for safety and quality in food therefore lies in the development and maintenance of adequate in-plant quality control programs. Promoting quality control at the plant level has become the primary goal of FDA regulation. In the past two years, a variety of new approaches to this goal have been put into operation. They include new techniques of inspection, sampling, and analysis, and a massive development of explanatory regulations and guidelines.

NUTRITIONAL LABELING

The nutritional quality of the diet has special importance to the older generation. Reduced income and problems in food selection and preparation can have serious effects on the health of this age group. This is one of the major reasons why the FDA has sought to motivate the food industry to a new sense of responsibility for the quality of the American diet. "Nutritional labeling" is becoming a dominant feature of food packaging for thousands of products.

More than 50 proposed, changed, or final regulations concerned with nutrition and labeling have been issued since March 1973. One of the most important of these, formally proposed on June 12, 1974, is designed to establish formally the national policy on food enrichment with added nutrients, such as vitamins, minerals, or protein.

Proposed nutritional quality guidelines aim to assure the consumer that he will not be short-changed in the nutritional values of such foods as breakfast cereals, main dish products, meal replacements, and vegetable protein products.

It is one thing to insure that foods are nutritious and informatively labeled, and another to get consumers to take advantage of nutritional labeling. The FDA has therefore entered the field of mass media nutrition education.

Simultaneously, the need for knowledge of consumer behavior in regard to food selection has been realized, and new studies undertaken to help determine how well or wisely the American consumer eats. Consumer research on food habits has more than nutritional significance. What people actually eat determines also their exposure to food additives and natural toxicants.

ARTIFICIAL SWEETENERS

Skyrocketing sugar prices and reports that industrial users were interested in switching to saccharin led to an FDA warning to food and beverage manufacturers that saccharin cannot legally be used as a substitute for sugar unless certain conditions are met. The only legal uses are in foods offered for calorie control and labeled as such, and certain technological uses. Sugar can be legally combined with saccharin only in diet beverages with a calorie content at least 50 percent less than in a product made entirely with sugar, and not exceeding six calories per fluid ounce. FDA enforcement personnel were instructed to take legal action against any violation of the regulations.

Approval was granted to market a new sweetener. Aspartame, a synthetic combination of two edible amino acids, has about four calories per gram. However, since it is 180 times sweeter than sugar, much less is needed to accomplish the desired sweetening effect, and therefore the calorie count becomes insignificant. Agency approval was given for the following uses: as a sugar substitute for table use, in tablet form for hot beverages, for use in sweetening cold breakfast cereals, for use in chewing gum, and for dry bases for beverages, instant coffee and tea, gelatins, puddings, fillings, and dessert toppings. Because aspartame loses its sweetness during prolonged cooking, it has not been approved for any foods which would require frying or baking.

A request that FDA rescind its 1969 ban of the artificial sweetener cyclamate was denied. FDA advised the manufacturer that the new data submitted was inconclusive and insufficient to refute the earlier studies indicating that cyclamates are not safe. FDA said additional data on the possible effects of cyclamate on reproduction organs and the cardiovascular system and on the levels of use, stability and assay methods, would be needed for a reconsideration.

VITAMIN LABELING CONTROVERSY

"Health food" interests have continued to campaign against FDA regulations to insure truthful informative labeling of vitamins, minerals and food supplements. Last year's report to the Committee on Aging covered the background and issues of the controversy in detail. The Food and Drug Administration and the Department of Health, Education, and Welfare continue to oppose bills designed to nullify the FDA regulations. Leading national organizations representing retirees and consumers support the FDA position. Their concern for the interests of consumers is shown by the attached release.[1]

ITEM 5. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

APRIL 22, 1975.

DEAR MR. CHAIRMAN: I am pleased to provide a statement summarizing major activities relating to older Americans carried out by the Department of Housing and Urban Development during 1974 as well as some followup efforts in 1975.

I would like to assure the committee that my Department will remain firm in its commitment to respond to the needs of our older Americans, and I look forward to working with you and your colleagues in the Congress in this regard.

Sincerely yours,

CARLA A. HILLS, *Secretary.*

[Enclosure]

INTRODUCTION

The Housing and Community Development Act of 1974, signed by President Ford on August 22, 1974, has provided two new major thrusts for community improvement and increased housing for needy persons.

Community development programs in the past were funded through individual categorical grants, requiring involved and complicated applications and long periods of processing time. Often the grants were made to communities on the basis of their "grantsmanship" ability—the skill in presenting a good application—rather than on the basis of the need for the funds.

Under the new act, the community development funds have been combined into block grants based on a needs formula, whereby most American communities will receive funds for local improvement. The formula takes into account the population, the extent of housing overcrowding, and poverty (counted twice). Applied against previous funding levels, the formula will assure communities of annual funds to carry out programs which will be developed and implemented locally.

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[1] Retained in committee files.

The other major new thrust is in the field of housing. The principal program for providing needed housing is in the form of housing assistance payments which will be made available to persons most in need of decent housing.

Other major HUD programs have been continued and improved—Housing Production and Mortgage Credit, including the Federal Housing Administration, is provided with more realistic limits of mortgage insurance; Housing Management has developed improved management systems to carry out the supervision of HUD assisted housing; Fair Housing and Equal Opportunity; Policy Development and Research, with its many studies and the experimental Housing Allowance Program; the Federal Insurance Administration, with increased emphasis on the Flood Insurance Program; the Office of Interstate Land Sales Registration, and the New Communities Program.

In the words of President Ford, "This bill is of far-reaching and perhaps historic significance, for it not only helps to boost the long-range prospects for the housing market but also marks a complete and welcome reversal in the way that America tries to solve the problems of our urban communities."

ASSISTANT TO THE SECRETARY FOR THE ELDERLY

The Department of Housing and Urban Development, which first established the position of Assistant to the Secretary for Elderly and Handicapped in the immediate office of the Secretary in 1972, has continued to demonstrate its special concern for the needs of the older Americans by undertaking a number of significant initiatives to strengthen and expand the scope of the activities of the Office of the Assistant to the Secretary, Programs for the Elderly and Handicapped.

In the spring of 1974, Secretary Lynn appointed a long time FHA employee, Mrs. Helen Holt, to be the new Assistant for Elderly and Handicapped, and directed that the Office, now fully staffed, be the focal point within HUD for all matters pertaining to housing and related facilities and services for the elderly and handicapped, and advise the Secretary on such matters.

Responsibilities specifically assigned by the Secretary include: reviewing the adequacy of pertinent HUD policies and procedures and participating in their development or revision, participating in planning for the inspection and evaluation of HUD assisted housing for the elderly, coordinating activities within HUD affecting the elderly and handicapped, and representing HUD in meeting with other Federal, state, and municipal or private organizations on matters affecting the elderly.

In order to help the Assistant to the Secretary for the Elderly carry out her responsibilities, an Interdepartmental Task Force on the Elderly, has been provided. The members of this task force represent each of the operating divisions of the Department, and they meet at least once a month to discuss major issues relating to the elderly.

INTERAGENCY COOPERATION

The Office of the Assistant to the Secretary for Elderly and Handicapped has been an active participant in the work of the Interdepartmental Working Group of the Domestic Council Committee on Aging. Through this group, the Department has been able to enter into a number of working agreements with other Federal agencies. These agreements cover such subjects as nutrition, transportation, energy and information and referral. A summary description of actions is being undertaken by HUD pursuant to each of these agreements follows:

NUTRITION

HUD recognizes that it and the Administration on Aging (AoA) share a common interest in serving residents of elderly housing through the Nutrition Program for older Americans and that a number of HUD housing developments for the elderly can offer facilities in their community space to serve as sites for the AoA Nutrition Projects, serving one hot meal a day not only to residents of the development but also to other elderly of the community.

The Department has agreed that in each State, local housing authorities and the management of other HUD assisted housing for the elderly will be alerted through HUD field offices to make contact with the State Agency on Aging. They will also identify the number of elderly residents reachable through the housing development; inform the State Agency on Aging about community space and facilities that can be made available; ascertain from the State Agency on Aging how and when participation may be brought about, and be instructed by HUD that Modernization Program funds can be utilized to accomplish alterations necessary in community space to accommodate meal preparation and service.

TRANSPORTATION

Management of HUD-insured housing for the elderly, Section 202 direct loan projects, and Local Housing Authorities have been urged to establish and maintain relations with their local transit authority and to explore: working with the local government to implement reduced rates for the elderly and handicapped; re-routing of transit lines to serve housing projects for the elderly and handicapped; adjusting schedules to accommodate the special transportation needs of the elderly and handicapped; and obtaining from the local transit authorities special services or facilities.

The management of HUD assisted housing for the elderly and handicapped and Local Housing Authorities will also post the transit maps and transit schedules of local transit authorities.

ENERGY

The Department has agreed to advise its field offices about elderly related energy conservation efforts and suggest that these offices provide state and area offices on aging with information concerning HUD Home Repair Programs. In addition, the Department will suggest to its field offices that they initiate discussions with state and area agencies on aging concerning the use of community space in HUD assisted elderly projects for energy conservation related activities.

INFORMATION AND REFERRAL

The Department has agreed to provide to the National Clearinghouse on Aging directories of HUD assisted housing for the elderly and HUD issuances pertaining to the elderly, and has reaffirmed the fact that HUD Area and Insuring Offices can answer general questions on elderly housing availability, eligibility for occupancy and questions of this nature. In addition, the Department has agreed that HUD assisted projects can provide a conduit for appropriate aging information and materials, and that these elderly projects may, in some instances, be able to provide information and referral sites in community space.

The Department expects to participate in a number of additional interagency agreements to be developed during 1975.

In addition to taking part in the multi-agency activity of the Interdepartmental Working Group, HUD, through the Office of the Assistant to the Secretary for Elderly and Handicapped is also working in close coordination with the Department of Health, Education, and Welfare pursuant to Section 209 of the 1974 Housing and Community Development Act.

Thus, an HEW/HUD review group has been established to identify and work toward the resolution of differences in the minimum property standards now used by the two Departments for housing for the elderly and the handicapped. This includes the related facilities of cafeterias or dining halls, community rooms or buildings, workshops, infirmaries or other inpatient or outpatient health facilities, and other essential service facilities.

A total of 22 members from both Departments participate on one of the three subgroups: steering, design/construction standards, or policy, management and operations. Farmers Home Administration and the National Bureau of Standards have been invited to participate in the sub-group deliberations.

The immediate goal of the group, with a target date of June 30, is to develop standards on design and on quality of services and management that will have the concurrence of both Departments.

COMMUNITY PLANNING AND DEVELOPMENT

During the past year, the categorical programs administered by the Assistant Secretary for Community Planning and Development which affect the elderly and handicapped have undergone a transition and been folded into the new community development block grant program, which became effective January 1, 1975. The only relevant categorical program remaining is the recently amended "701" Comprehensive Planning and Management Assistance Program. Both the block grant program and the "701" program have significant potential for aiding elderly and handicapped persons.

In August 1974, President Ford signed into law the Housing and Community Development Act of 1974, authorizing $11.9 billion over a three year period; including $8.75 billion for community development activities under Title I and $287 million for comprehensive planning under Title IV. Title I consolidates the following previously categorical programs: Urban Renewal/NDP, Model Cities, Water and Sewer Grants, Neighborhood Facilities, Public Facility Loans, Open Space Land and Rehabilitation Loans. Title IV amends Section 701 (Comprehensive Planning) of the Housing Act of 1954.

While benefiting all Americans, the New Housing and Community Development Act of 1974 includes a number of provisions which focus specifically on the needs of the elderly and handicapped.

COMMUNITY DEVELOPMENT BLOCK GRANTS

The standards set forth in the Architectural Barriers Act of 1968 would, of course, apply to any new facility constructed from the $8.75 billion in Community Development Block Grants. This represents a major step toward eliminating architectural discrimination against the handicapped. In addition, "special projects (may be undertaken) directed to the removal of materials and architectural barriers which restrict the mobility and accessibility of elderly and handicapped persons."

Under Title I, these "special projects" might include structural additions to buildings to help persons with mobility, manual, visual or auditory impairments. For example, elevators or rest rooms might be adapted to their requirements; a railing may be installed to prevent falls or special lighting added to reduce glare for the partially blind. Other projects might include: grading pedestrian ways to eliminate steps, providing ramps at street corner curbs, eliminating drainage grates hazardous to wheelchairs and trash receptacles, drinking fountains, public telephones at wheelchair height. Benches in public areas help persons with problems (serving pregnant women and children as well). Funds might also be spent on recreation areas usable by the elderly and handicapped with swimming pools that accommodate wheelchairs, or campgrounds, wooded trails, fishing and boating docks that provide barrier-free accessibility.

SENIOR CENTERS

Senior centers are specifically included as an eligible activity, and Title I funds may also be used for public services not otherwise available, if supporting other block grant activities—services such as sheltered workshop, day care, or Braille instruction within a neighborhood facility or the salary of a lifeguard at a public swimming pool for the handicapped. In addition, Title I funds may pay for the non-Federal share of those Federal grant-in-aid programs covering activities which would otherwise be eligible under Title I undertaken as part of the community development programs, thus extending the range of Federal social programs serving the elderly and handicapped within each community.

Discretionary grants are available for innovative projects which encompass concepts, systems, or procedures that are unique, significantly advance community development technology, and have the potential for transferability to other communities.

HOUSING PLAN

Finally, Title I requires a plan estimating the housing needs of lower-income persons, including elderly and handicapped persons, residing or expected to reside in the community, examining the condition of the housing stock, establishing a realistic annual goal for new and rehabilitated units, and determining their distribution.

The HCD Act of 1974 requires that local citizens be provided with adequate information concerning the amount of funds available for community development activities and the range of activities permitted. The grantee must develop a plan for citizen participation, must hold at least two public hearings to obtain the views of citizens on community development needs, and must provide an adequate opportunity for citizen participation in developing the application and its amendments. The final determination of application content rests with the official governing body of the community. Citizens may recommend, but not mandate, that particular projects to aid the elderly and handicapped be included, and must compete in this regard with other special interest groups within the community.

Citizens supporting the interests of the elderly and handicapped may monitor programs of new construction to insure that they conform to the requirements of the Architectural Barriers Act, and may encourage affirmative action for the employable elderly and handicapped in filling jobs generated by the grant.

COMPREHENSIVE PLANNING ASSISTANCE

Although Title I funds may also be used for planning and management, the nature of the planning undertaken is limited in scope to activities eligible under Title I.

Title IV of the Housing and Community Development Act of 1974, however, provides funds for developing and implementing a comprehensive plan and a management and policy-planning evaluation capability. The plan must include a housing element which promotes the realization of a decent home and suitable living environment for every American family, and a land use element which addresses significant land use problems. Both elements can offer opportunities for determining community development goals and policies for the elderly and handicapped, including decisions on alternate locations for senior citizen recreational activities, playgrounds for the blind, gerontological clinics, schools for the deaf, elderly housing projects, homes for the mentally retarded, vocational rehabilitation centers, and transportation for the elderly and handicapped. Citizens must be notified and involved in developing and modifying the comprehensive plan, although final determinations, as with Title I, are made by the official governmental decisionmakers.

The impact of both the block grant program and the amended "701" program in aiding the elderly and handicapped should become evident as both programs become operational during 1975.

HOUSING PRODUCTION AND MORTGAGE CREDIT

The new provisions of the Housing and Community Development Act of 1974, will generate increased housing activity on behalf of the elderly, particularly through the new Section 8 Housing Assistance Payments Program, the revised Section 202 program, and the encouragement of congregate-type housing. At the end of 1974, the number of housing units specially designed for the elderly under HUD's various housing programs totalled more than 460,000.[1]

SUBSIDIZED HOUSING PROGRAMS FOR THE ELDERLY

SECTION 8—HOUSING ASSISTANCE PAYMENTS

With the passage of the 1974 Housing and Community Development Act, HUD central office staff began developing regulations for the new Section 8 program of housing assistance payments. Regulations for new construction and substantial rehabilitation were issued on December 30, 1974, with those for existing housing following shortly thereafter on January 23, 1975.

Under the Section 8 program, HUD will provide housing assistance payments on behalf of eligible lower income families (whose incomes do not exceed 80 percent of median income for the locality) occupying newly constructed, substantially rehabilitated or existing housing. These payments will make up the difference between the approved rent for the unit and the amount the family will be required to pay, which is not less than 15 percent or more than 25 percent of the family's adjusted income.

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[1] All data for 1974 are preliminary; some program statistics were available only through June or September.

NEW CONSTRUCTION AND SUBSTANTIAL REHABILITATION

Areas first will be geographically divided by the field offices, usually by SMSA or at least one county. HUD then will issue invitations for specific numbers of units by geographic areas. In response to these HUD-published invitations for proposals, prospective participants (which may be profit-motivated or non-profit groups, as well as public housing agencies) will submit development proposals to be reviewed by HUD in light of specified criteria and in relation to other proposals submitted. If both the preliminary and final proposals are acceptable to HUD, the Department will enter into an agreement that upon completion of the project, it will enter into a Housing Assistance Payments Contract with the owner for a specified term. Under this Contract, HUD will make housing assistance payments with respect to units occupied by eligible families.

The gross rents approved under the Contract generally may not exceed the HUD-established Fair Market Rents for the housing market area in which the project is located. Rents also must be reasonable in relation to the quality, location, amenities, methods and terms of financing, and the management and maintenance services for the project. The Fair Market Rents may be exceeded by up to 10 percent where the HUD field office director determines that special circumstances so warrant and the rents meet the test of reasonableness. The Fair Market Rents may be exceeded by up to 20 percent where the Assistant Secretary for Housing Production and Mortgage Credit determines special circumstances so warrant, or determines that such higher rents are necessary to the implementation of a Housing Assistance Plan (normally required to be submitted by communities in accordance with Section 213 of the HCD Act of 1974). The provisions for higher rents, where warranted are expected to provide the necessary flexibility for sponsors to provide the special amenities needed by the elderly.

EXISTING HOUSING

The provisions for participation in the Section 8 program by owners of existing housing are expected to be of particular interest to the elderly. If an elderly person or family is living in or finds a suitable rental unit, the owner is willing to lease and certain conditions are met, a lease may be executed between the owner and the family, and a Housing Assistance Payments Contract will be executed between the public housing agency and the owner.

SECTION 202—DIRECT LOANS FOR HOUSING FOR THE ELDERLY

The 1974 Act also authorized HUD to make up to $800 million in direct loans under a revised Section 202 program. The 1975 Supplemental Appropriation Act, signed by the President on December 27, included $100 million for this program and stipulated such funds were to be supplemented by using unobligated balances already in the Section 202 program fund as of December 31, 1974, estimated to be about $115 million. It is anticipated that the $215 million thus provided by Congress will be sufficient to finance construction of approximately 10,000 units. It has been determined that HUD will make these direct loans for rental housing for the elderly and handicapped only to finance the construction phase of such housing projects that are sponsored by non-profit organizations and assisted under the Section 8 Housing Assistance Payments Program. The interest rate on the Section 202 loans will be equal to the average Treasury borrowing rate on debts with comparable maturities, plus an allowance to cover administrative costs and anticipated losses. Permanent financing for these projects will be arranged through the same avenues of FHA-insured or conventional financing as are available for all other Section 8 projects.

The construction loan approach to implementing the Section 202 program will permit the available level of funding to be rolled over more frequently. This means that rather than tying up funds in 40- to 50-year permanent loans, the same funds can be reused many times over that period of time (subject to Congressional and budgetary authority) to develop numerous projects.

Regulations and processing instructions are now being developed to implement this program.

RENTAL ASSISTANCE PROGRAM

Section 236(f)(2), as added to the National Housing Act by the HCD Act of 1974, is designed to assist tenants in Section 236 projects who cannot afford to pay the basic rents within 25 percent of their income, by providing for HUD to make rental assistance payments to the project owners on behalf of such tenants. This program will be structured along the same lines as the rent supplement program. Generally, the rental assistance payments may not be made with respect to more than 20 percent of the dwelling units in a project. However, the Secretary may reduce or increase that percentage in certain circumstances. Where the tenant's utilities are included in the rent, the tenant's portion of the rent could be reduced to as low as the utility costs for his unit, or even lower under certain conditions. Therefore, a deeper subsidy is possible under the rental assistance program than under the rent supplement program. This should be particularly beneficial to the many elderly who reportedly pay as high as 50 percent of their income for rent.

Regulations and processing instructions are expected to be issued in the very near future.

UNSUBSIDIZED HOUSING PROGRAMS FOR THE ELDERLY

SECTION 232—MORTGAGE INSURANCE FOR NURSING HOMES/INTERMEDIATE CARE FACILITIES

The primary objective of the Section 232 program is to assist and promote the construction and rehabilitation of long-term care facilities. Since 1959 when this program was enacted, the Department has insured mortgages for 997 facilities, providing more than 108,000 beds.

Approximately 90 percent of the residents of nursing homes are elderly. Although the elderly generally have low incomes and often otherwise could not afford nursing home facilities, HEW's medicare and medicaid programs have made it possible for many more elderly persons to benefit from nursing home services provided under this program.

SECTION 232 (i)

There has been a substantial amount of interest in the new Section 232(i) program of supplemental loans established by Public Law 93-204, to finance the purchase and installation of fire safety equipment. Regulations were issued on August 12, 1974, and the program now is operational. To be eligible as a borrower, the applicant must be a profit or non-profit entity, which owns a nursing home or intermediate care facility for which the Secretary of Health, Education, and Welfare has determined that the installation of fire safety equipment is necessary to meet the applicable requirements of the Secretary of HEW for providers of services under Title XVIII and Title XIX of the Social Security Act. There also must be a determination that upon completion of the installation of such equipment, the care facility will meet not only HEW's applicable fire safety requirements, but also will meet HEW's other pertinent health and safety requirements for providers of such services.

SECTION 231—MORTGAGE INSURANCE FOR ELDERLY HOUSING

The Section 231 program is HUD's major program for developing unsubsidized rental housing for the elderly. Under this program, the Department is authorized to insure lenders against losses on mortgages for the construction or rehabilitation of rental housing for the elderly and handicapped. Although Section 231 is intended primarily for the unsubsidized market, non-profit sponsors of projects have also been eligible for participation in the rent supplement program. In addition, Section 231 is one of the eligible financing methods for housing being developed under the Section 8 Housing Assistance Payments Program. Activity under this program has continued at a modest level, although it might be expected to increase with the implementation of the new Section 8 program.

Section 231 provides mortgage insurance for up to 90 percent of replacement cost in the case of profit-motivated sponsors and up to 100 percent of replacement cost for non-profit sponsors. The current maximum interest rate is 8 percent plus one-half of 1 percent mortgage insurance premium.

SECTIONS 221 (d) (3) AND 221 (d) (4)—MORTGAGE INSURANCE PROGRAMS FOR MULTIFAMILY HOUSING

Although the Sections 221(d)(3) and 221(d)(4) programs are not specifically geared to housing for the elderly, these market rate programs are available to sponsors who are interested in alternatives to the Section 231 program. A few of the differences between these two programs and Section 231 include per unit cost limits and the types of eligible sponsors. Section 221(d)(3) projects may be sponsored by limited divided groups and mortgage limits are somewhat lower than Section 231. Section 221(d)(4) projects may be sponsored only by profit-motivated groups and have the same per unit mortgage limits as the Section 231 program.

REFINANCING OF EXISTING MULTIFAMILY HOUSING

This program may be of interest to a sponsor who finds it desirable, for one reason or another, to refinance an existing facility. The proposal might involve a straight refinancing or refinancing with some minor repairs. Since under other mortgage insurance programs the project would not be eligible unless substantial rehabilitation were required, the Section 223(f) program could be utilized.

HOUSING MANAGEMENT

In the Fall of 1974 Housing Management established a four member Special Concerns Staff which is responsible for the management needs of the elderly, handicapped, congregate, nursing home and transient residents, and for security in HUD assisted housing. The Special Concerns Staff:

Develops policies, procedures, and programs for the special management needs of elderly, handicapped, congregate, nursing home and transient residents, and for security in HUD assisted housing;

Provides technical advice and assistance and training in areas of its specialized expertise;

Coordinates with organizations of other Assistant Secretaries matters affecting management needs of these special residents including HM input into production affecting architecture, community space, safety, security and location factors;

Develops and recommends HUD publications required for use by HUD staff, LHAs, private management groups, tenant groups and others covering security in housing and the management concerns affecting these special residents;

Maintains liaison with Federal, state, local, governmental and private agencies and non-profit organizations concerning aging (including handicapped) and security;

Monitors and evaluates management and security and progress, estimates needs in elderly housing management and in the security aspects of HUD assisted housing.

TRAINING

In the fall of 1973, each HUD Assistant Regional Administrator for Housing Management and the Director of the Housing Management Division of each HUD Area Office, appointed a two-person Security Specialist Team. Each team consists of a maintenance engineer whose concerns are the hardware aspects of the security and a community services advisor who would concern himself with security software. Throughout 1974, a series of training institutes were conducted by Temple University to train over 300 of these specialists and related professionals at the local housing authority level.

Also during 1974, a contract was awarded to Temple University to develop a curriculum that can be duplicated throughout the country, for the training of Housing Managers of Elderly Housing Projects.

TRANSPORTATION

The Office of Housing Management and the U.S. Department of Transportation signed a joint agreement in December of 1974 initiating a cooperative effort by the two Federal departments to improve transportation facilities for the elderly and handicapped persons living in HUD assisted housing.

HUD's community service advisors and DOT officials will cooperate in two major efforts: to coordinate mass transportation services for the elderly and handicapped with existing transportation services and to make capital grants and loans from DOT funds to private nonprofit corporations to assist them in meeting their transport needs.

SECURITY

The Special Concerns Staff has continued to focus on the safety and security of the elderly person. The elderly have consistently been identified as the most victimized public housing and other HUD assisted housing residents. Contracts are now being worked out to develop films, TV spots, booklets, and leaflets on security in public and private housing for the elderly. These are to be used in training workshops with local housing authorities and tenants.

A planning security handbook, "Security Planning for HUD Assisted Multifamily Housing," which incorporates HUD's security concepts to date, is in distribution. In a step-by-step manner, the handbook covers the role of management in organizing and implemeting a security program. One section, "Special Considerations Regarding Elderly Residents," concerns itself with the problems of and opportunities for the elderly; the question of separation of elderly and families; and security for exclusively elderly residents of family projects.

Housing Management is also distributing a booklet, "Guidelines 2—A Design Guide for Improving Residential Security," which was prepared by the Office of Policy Development and Research. This booklet deals with the hardware aspects of security and has been distributed to all Housing Management maintenance engineers.

The "Low Rent Community Services Program Guide on Developing a Comprehensive Security Program for Multifamily Units" has been prepared and distributed to the community services officers throughout the nation.

The following articles dealing with residential security, were published in the HUD Challenge magazine in 1974. These articles are currently being assembled with several others to form a special issue devoted entirely to Residential Security: "Turf Reclamation," An approach to Neighborhood Security, Seymour J. Rosenthal, March 1974; Jersey City's Experiment in Tenant Safety, Neil S. Piro, May 1974; Self-Help Crime Prevention Program, Ferris Lucas, May 1974; Crime Prevention for the Elderly, George Sunderland, September 1974; New York's Experiment in Tenant Safety, Samuel Granville, September 1974; Federal Crime Insurance Program, James M. Rose, Jr., October 1974; and Measuring Residential Security, William H. Brill, November 1974.

NUTRITION PROGRAM

Housing Management maintains continuing contact with the Administration on Aging in order to gain knowledge of their Nutrition Program as well as to pursue ways in which collaboration between the two organizations can be enhanced. A member of the Housing Consumer Division staff serves on AoA Commissioner Arthur Flemming's Interdepartmental Task Force on Nutrition as well as on his Interdepartmental Task Force on Information and Referral. Some 160 Local Housing Authorities have provided facilities for the meals program over the past year. In a few cases, the housing agency has been a grantee as well. In more than one case, the community facility within the project, which is utilized for the Nutrition Program, has added other programs in recreation, health education and referral services. Elderly residents in nearby communities and residents of the housing projects are accommodated.

ELDERLY HOUSING DIRECTORY

Finally, the Special Concerns Staff has prepared and HUD will distribute a directory of all "Housing Developments for the Elderly". The developments are listed by state, and include names, addresses, size and nature of financing of projects.

Policy Development and Research

Title V of the Housing and Urban Development Act of 1970 authorizes and directs the Secretary to undertake programs of research, studies, testing, and demonstrations relating to the mission and programs of the Department. This includes encouraging and promoting the acceptance and application of advanced methods, technology, and materials by the general public and by the housing industry, communities, and industries engaged in urban development. Section 815 of the Housing and Community Development Act of 1974 strengthened the role of HUD research in the areas of elderly and handicapped by specifically encouraging demonstrations into the problems of members of special user groups, including the elderly and handicapped.

The Assistant Secretary for Policy Development and Research is responsible for the development, planning, execution and evaluation of HUD research programs; for making research results available for use in the development and evaluation of Department policy, and for disseminating these research results to decision-makers at all levels of Government and in the private sector. The HUD research program is intended to serve as a stimulus for positive change by conducting technological and managerial research, by demonstrating new systems and methods for application by other elements of government and private enterprise, and by generally improving knowledge of the housing and community development processes. The program serves as a national focal point for housing and community development research, and as a central point for research, analysis, data collection and dissemination.

SPECIAL USER RESEARCH

The focus on research related to the problems of the elderly and handicapped is in the Special Research Program, although other program areas such as Community Design Research and Economic Affairs also support research which impacts on the elderly and handicapped.

The mission of the Special User Group Research Program is to design, conduct and support research and demonstration projects whose results will improve housing conditions and related housing and community services for the elderly, the handicapped, and other members of identifiable special user groups. The focus of the Special User Group Research Program is on five areas: improved design and technology financing mechanisms, service delivery, housing management and the integration of past findings into current operating programs.

CURRENT RESEARCH

The Office of Policy Development and Research is currently sponsoring several projects related to the housing problems of the elderly and handicapped, and additional projects will be undertaken during Fiscal Year 1975. The following list demonstrates the scope of these ongoing projects:

An evaluation of the effectiveness of existing property tax relief measures nation-wide, and the development of model improvements in administration, incidence, eligibility, and cost;

The development of a program of maintenance and repair assistance tailored for elderly homeowners, which also includes a study of sources of appropriate financing and means to educate the elderly to assess their own maintenance and repair needs and to more effectively plan for their accomplishment;

A demonstration of a housing information and referral service staffed primarily by elderly volunteers;

The revision, broadening an extension of the existing American National Standard for Accessible and Usable Buildings to include dwellings and their related exterior spaces;

An evaluation and demonstration of mobile homes specially adapted for use by the severely handicapped;

Further research in the use of a sheltered housing environment for the severely handicapped to determine whether persons with different types and degrees of disabilities benefit differently from residence there, and if so, what this would suggest in determining target populations for operating programs.

FUTURE RESEARCH

The great majority of the research sponsored by the Office of Policy Development and Research is done through competitively awarded contracts. It is customary to prepare and release Requests for Proposals and then to select a contractor from among the proposals received in response to the RFP. During this fiscal year the Department will be releasing these RFP's which relate to the needs of the elderly and handicapped:

An evaluation of the effectiveness of existing congregate housing in meeting the needs of elderly persons no longer able to live independently, but not yet in need of medical supervision;

A guidebook for the conversion of family housing or other facilities to housing for the elderly, concentrating on the needs for public and service space;

An evaluation of the cost effectiveness of requiring that a specified percentage of all of the Department's multifamily housing units be set aside for and accessible to the handicapped.

HOUSING ALLOWANCE EXPERIMENT

The Department of Housing and Urban Development is conducting a major research effort, the Experimental Housing Allowance Program, to evaluate the concept of channeling Federal assistance directly to families in need of housing instead of through organizations in the business of providing housing. The program, authorized by the Housing Act of 1970, is being conducted as a part of the Housing Assistance Research Program under the direction of the Assistant Secretary for Policy Development and Research.

The experimental program will produce information upon which to base key decisions: First, the decision as to whether the direct assistance approach is in fact a tenable one; and decisions as to how and in what form the direct assistance can best be administered.

The direct assistance approach is not a new idea. What is new is the idea of a detailed, methodical research effort to determine the values—pro and con—of such an approach and to test alternative administrative mechanisms for initiating a full-scale operating program.

Three elements, which form the basis for a full analysis of an operating housing allowance program, make up HUD's Experimental Housing Allowance Program. Although these elements were not designed to focus specifically on the problems of the elderly in the housing market, some information will be gained in the context of the analyses that were planned. The three elements are briefly described below:

A supply experiment will provide information on the market effects of a full-scale, operating housing allowance program. About one-fourth of participating households are expected to be elderly. Plans call for assistance to be given both renters and homeowners.

Initial reports from this experiment will be prepared by late 1975. Large amounts of data will be available and special analyses of the elderly participants can be made at that time.

The demand experiment completed its enrollment at the end of February 1974. About 20 percent of the participants are elderly households. The focus of the Experiment is the participant family and its experiences under carefully controlled variations, and a wide variety of interviews and survey data is being collected, including information on the quality of housing and neighborhoods, participant initiative, locational choices, maintenance and rehabilitation, and cost factors. In some of the analyses planned, elderly participants will be compared with other age groups on such questions as quality of housing, satisfaction with their homes and neighborhoods, and the degree to which they move. They will be consistently observed as a relevant subgroup throughout the experiment. Reports from the Demand Experiment are scheduled for fall 1975 through 1977.

The administrative agency experiment (AAE) was designed to determine experimentally the most satisfactory and cost-effective management procedures that may be used under varying conditions in the delivery of a housing allowance program. Since one measure of a successful administrative process or function is the effect on the participant, data regarding participating attitudes, responses and experiences are being gathered in several different contexts, including from agency record keeping, from surveys, and from in-depth participant case studies.

The final enrollment period was completed in May 1974, and the final number of recipients was 5,512 with about 17 percent (950) being elderly households. Several reports from the AAE will be completed in 1975 and these will contain some information on elderly participants. For example, the Enrollment Process report, received in January 1975, but not yet fully analyzed, contains information on whether or not there are age differences in participant reactions to the administrative functions of outreach, screening, certification and enrollment. Similarly, the report on Participant Services, due in October 1975, will have information on the extent to which elderly participants attended counseling sessions and some descriptive data on the extent to which they required special counseling services. Reports on the other administrative processes contain similar reports of findings by age group where relevant results are found.

Special Study of the Elderly (under the AAE).—Since there are considerable data available in the AAE of particular relevance to the elderly, the evaluation contractor was asked to conduct a special study, including a special survey, to gain certain additional information from the AAE elderly subsample. This study focuses on such questions as how the elderly recipient use their housing allowance, the ability of elderly households to shop for housing, the relationship of the housing allowance to the special needs of the elderly, and the delineation of an appropriate outreach, application and enrollment system for the elderly. The study was carried out during the summer and fall months of 1974, and the results will be available in early 1975.

New Communities

Through legislation passed in 1970, the Federal government can guarantee mortgages for developers of large scale new communities which meet certain requirements, including provision of an economic base, provision of substantial amounts of low and moderate income housing, good physical and social planning and provision of adequate community amenities and facilities including education, health, culture and recreation.

All of the 16 new community projects approved for Federal assistance by the end of 1974 will provide housing, community facilities and amenities which will have special value to the elderly and handicapped. These include barrier-free access to public buildings, pathway systems separated from vehicular traffic and ready access from homes to shopping, recreational facilities, and neighborhood facilities.

BARRIER FREE DESIGN REGULATIONS

Draft regulations for the new Community program contain the following paragraph:

> The new community will include adequate planning of walks and grounds and appropriate buildings to take into account the special barrier free needs of the physically handicapped and the elderly. Design standards shall include the Department's standards for public housing (40 FR 24), the FHA Minimum Property Standards, the General Services Administration standards for public buildings (101-17-RF-41) and standards published in 1964 by the American National Standards Institute. The developer shall coordinate the design standards on all buildings in the new community. The developer will make his best efforts to incorporate, where appropriate, barrier free design requirements on land development activities by others through recording of appropriate covenants and restrictions on the land.

Under these regulations, population projects for the new community will be broken down into ten age categories, including two categories for the elderly (55-70 and 70 plus), so that housing and public facilities can be provided for these age groups in proper amounts and sequence. Further, the number of physically handicapped in each age category is projected so that appropriate design considerations can be made for this group.

The regulations further permit incorporation of nonprofit community associations which will own and manage facilities and provide services to residents. Generally, the regulations state that these community associations will charge dues "which are available to, and affordable by, all residents including the elderly, persons from low income families, the handicapped, and renters. These may include such facilities as certain parks and playgrounds, walkways, lakes, tennis courts, swim clubs, community centers, and such services as community recreation programs, community information services, broad appeal training, cultural and counseling services, and community center operation."

NEW COMMUNITY PROJECTS

New community projects in which substantial construction of facilities for the elderly are either underway or completed are:

Roosevelt Island, N.Y.—Some 250 apartment units for the elderly are under construction on this new community near Manhattan and are scheduled for occupancy early in 1975. Also, ready access to health services will be offered Roosevelt Island residents by existing hospitals on the island. Barrier-free access to buildings and facilities is provided in the new community design, and apartment structures are multi-use, some containing schools and social services. Private autos are banned from the island's streets and mini-bus transportation will provide ready access throughout the island. A rapid transit station will eventually provide transportation to jobs in downtown Manhattan and the New Jersey communities.

Cedar-Riverside, Minn.—Enclosed walkways provide convenient access for elderly residents to public and commercial activities.

Jonathan, Minn.—Forty units of housing for the elderly (236) are under construction. A medical cable television system will provide diagnostic medical examinations.

INTERSTATE LAND SALES

Congress passed the Interstate Land Sales Full Disclosure Act in 1968, to give the public a measure of protection against fraudulent and deceptive land sales operations. The Act is administered through HUD's Office of Interstate Land Sales Registration. Although the major impetus for the Act stemmed from land sales frauds perpetrated on the elderly, the Act is intended to provide protection for all consumers, and experience since inception of the Act indicates that the fraudulent practices sought to be stopped transcend age lines and often involve investment pitches to families.

The Property Report is the key to the protection available to consumers under the Act, since developers are required by law to give the prospective purchaser a Property Report before or at the time of signing a contract. The disclosure contained in a Property Report covers such items as: (1) existence of mortgages, liens and other encumbrances; (2) whether contract payments are set aside in a special (escrow) fund; (3) availability of recreational facilities, where and when; and (4) availability of water and sewer facilities or of wells and septic tanks.

In 1974, the Interstate Land Sales Full Disclosure Act was amended to extend the time purchasers have to void their contract or agreement if they receive a Property Report less than 48 hours before signing the contract or agreement. The Act previously afforded a "cooling-off" period of 48 hours. The amendment provides a "cooling-off" period of three business days following the consummation of the transaction.

In addition, the Statutory provision with respect to waiver by a purchaser of his revocation rights because he made an on-site inspection and received, read and understood the Property Report has been repealed.

These amendments to the Act give the general public and elderly greater protection against fraudulent and deceptive land sales practices.

FEDERAL DISASTER ASSISTANCE

In addition to the Federal Disaster Assistance Administration's stated objective that disaster assistance is based on the needs of individuals and their families, and shall be given without regard to race, color, religion, nationality, age, sex or economic status prior to the disaster, preparedness activities have placed a great deal of emphasis on encouraging the States to consider the special problems of the aging in their disaster preparedness efforts.

Specific references to this effect have been included in guidance provided to the States (Disaster Preparedness Checklist) and FDAA regional staff of the Administration on Aging (HEW) for discussions on this matter.

ITEM 6. DEPARTMENT OF THE INTERIOR

FEBRUARY 18, 1975.

DEAR SENATOR CHURCH: This is in reply to your letter of December 20, 1974, requesting a paper summarizing major activities on aging during 1974.

The Department is participating in the Retirement Advisors, Incorporated Program, and for the third year interested employees within 5 years of retirement eligibility are receiving informational booklets on retirement and topics relating to aging.

Duplicate copies of material issued to retirees by some of our bureaus are enclosed.*

The Golden Age Passport is issued at no charge and given to persons 62 years of age or older. It is valid for the lifetime of the permittee. All passport holders will be given 50 percent discount on all designated recreation fee facilities and services provided by the Bureau of Land Management.

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*Retained in committee files.

We have no specific plans for 1975, other than continuation of our participation in the Retirement Advisors, Incorporated Program, as well as our individual counseling efforts.

Sincerely yours,

THEODORE C. KRELL,
For Director, Organization and Personnel Management.

ITEM 7. DEPARTMENT OF LABOR

MAY 14, 1975.

DEAR MR. CHAIRMAN: This is in reply to your request of December 20, 1974 for a statement from the Department of Labor for your annual report to the Senate, *Developments in Aging.* I am enclosing a report from the Manpower Administration dealing with its employment programs for older workers as well as the services it provides them through the United States Employment Service. A second report from the Employment Standards Administration summarizes our activities to improve and protect the employment opportunities of older workers under the Age Discrimination in Employment Act. More detailed information on our antidiscrimination activities is contained in the report we annually submit to Congress in accordance with section 13 of the Age Discrimination in Employment Act of 1967.

The Employee Retirement Income Security Act of 1974 (ERISA), which sets comprehensive Federal standards for the operations of private sector employee retirement and welfare plans, gives the Secretary of Labor primary authority for administering and enforcing the disclosure and fiduciary responsibility provisions, and secondary responsibility regarding the participation, vesting and funding standards of the new law. Since the disclosure and fiduciary responsibility provisions became effective on January 1, 1975 and the other major standards are not applicable for most plans until plan years beginning in 1976, we look forward to reporting fully on these activities in the future. We expect that our joint efforts with the Internal Revenue Service under ERISA will result in improved administration of employee benefit plans and, as a consequence, that an employee covered by a retirement plan can look toward his or her old age with greater assurance that the benefits promised will materialize when and as promised by the plan.

Title IV of ERISA established the Pension Benefit Guaranty Corporation (PBGC) to administer an insurance program for situations in which pension plans terminate without sufficient assets to pay certain basic benefits. As Secretary of Labor, I am Chairman of the Board of the Corporation, and it is my pleasure to furnish you with a brief report of [illegible] activities of the PBGC to date.

Sincerely,

JOHN T. DUNLOP,
Secretary of Labor.

[Enclosures]

SUMMARY OF PROGRAMS AND SERVICES FOR OLDER WORKERS

U.S. DEPARTMENT OF LABOR, MANPOWER ADMINISTRATION

I. SPECIAL EMPLOYMENT PROGRAMS

The Manpower Administration of the Department of Labor administers two special employment programs for the elderly. They are the National Older Workers Program-Operation Mainstream (NOWP–OM) and the Senior Community Service Employment Program (SCSEP). The NOWP–OM, originally set up under the Economic Opportunity Act, is now being funded on a temporary basis under title III of the Comprehensive Employment and Training Act of 1973. The SCSEP is funded under title IX of the Older Americans Comprehensive Services Amendments of 1973. Differing only in size and legislative authority, these two programs are intended to provide part-time jobs for elderly poor persons and to provide the communities in which they operate with a federally subsidized pool of manpower which can be drawn upon to upgrade existing human services or to establish new ones.

Activity under both programs is sponsored almost entirely by a group of five national level organizations, most of which have participated in the NOWP–OM since 1968. These organizations were also involved in the startup of the SCSEP which began in June 1974. The five organizations are: (1) Green Thumb, Inc., an arm of the National Farmers Union; (2) the National Council on the Aging; (3) the National Council of Senior Citizens; (4) the National Retired Teachers Association-American Association of Retired Persons; and (5) the U.S. Department of Agriculture Forest Service. In total, they operate local projects in 47 States, Washington, D.C., and Puerto Rico. Local projects are administered by the staff of the national organization or are, in a number of cases, administered by locally based service agencies under subcontractual arrangement with the national organization. Each local project is required to coordinate its activities with the CETA prime sponsor and the State or area agency on aging. In addition, regionally administered SCSEP program grants have been awarded directly to three State and four territorial governments: Alaska, Delaware, Hawaii, American Samoa, Guam, the Trust Territories of the Pacific Islands, and the Virgin Islands.

Local projects under the NOWP–OM and the SCSEP hire economically disadvantaged persons, 55 years old or older, to work in part-time community service jobs. With their wages fully subsidized by the program, participants work in a wide variety of community service activities, including day care centers, senior citizen centers, nutrition programs for the elderly, home-health care projects, hospitals, schools, and beautification, conservation and restoration projects (including many in the national forests). The work activities of program participants are, in many cases, supervised by local project staff. In many other cases, participants are given work assignments at host agencies, such as the local welfare office, a local school or day care center, where the work activities are supervised by the agency's staff. In addition to providing part-time job opportunities, local projects also provide other services to participants, including yearly physical examinations, personal and job-related counseling, consumer information, job training, and referral and placement into regular unsubsidized jobs.

Within the framework of existing legislative authority, the Manpower Administration is reviewing alternatives for the continued funding of these older worker employment programs. It is felt that steps can be taken to ensure that program operations are maintained in the coming fiscal year.

The two charts which are attached summarize (1) costs, enrollment levels, and turnover experienced by both programs during the first two quarters of fiscal year 1975 and (2) the aggregate characteristics of persons enrolled in both programs as of December 31, 1974. These charts reflect program activity sponsored by the five national level organizations only. They do not reflect the projects sponsored by the three State and four territorial governments mentioned previously.

NATIONALLY ADMINISTERED OLDER WORKER PROGRAMS

COST AND OUTPUT TABLE FOR THE PERIOD JULY-DECEMBER 1974

Program factors	NOWP-OM			SCSEP[1]			Composite		
	Plan	Actual	Percent of plan	Plan	Actual	Percent of plan	Plan	Actual	Percent of plan
Obligations (in thousands)	$20,000	$20,042	100	0	0		$20,000	$20,042	100
Costs (in thousands)	$13,786	$13,863	101	$2,500	$2,232	89	$16,286	$16,095	99
Man-years (estimate)	4,660	4,692	101	736	657	89	5,396	5,349	99
Cost per man-year (estimate)	$2,957	$2,954	100	$3,400	$3,400	100	$3,019	$3,009	100
Enrollees carried over from fiscal year 1974		9,343			0			9,343	
New enrollees	2,778	2,977	107	3,375	3,284	97	6,153	6,261	102
Unsubsidized placements	750	898	120	75	73	97	825	971	118
Dropouts	2,150	2,212	103	300	275	92	2,450	2,487	102
Current enrollment (EOP)	9,223	9,210	100	3,000	2,936	98	12,223	12,146	99

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[1] Because fiscal year 1975 represents the startup year for the SCSEP, costs and man-years will accelerate rapidly in the last 2 quarters of the fiscal year. Because enrollment levels were necessarily unstable (i.e. increasing rapidly) during the 1st 2 quarters, it was not possible to get an accurate fix on the number of man-years achieved. Therefore, the number of man-years reported was based on the costs reported and our estimated cost per man-year. The cost per man-year estimated for the 1st 2 quarters is slightly higher than the planning estimate for the entire fiscal year in recognition of the higher administrative cost ratio normally expected for a startup effort.

NATIONALLY ADMINISTERED OLDER WORKER PROGRAMS

SUMMARY OF PARTICIPANT CHARACTERISTICS, PERSONS ENROLLED AS OF DEC. 31, 1974

[In percent]

	NOWP-OM (9,210 persons)	SCSEP (2,936 persons)	Composite (12,146 persons)
Sex:			
Male	55.2	46.6	53.1
Female	44.8	53.4	46.9
Age:			
54 and younger	1.6		1.3
55 to 64	40.0	52.7	43.0
65 and older	58.4	47.3	55.7
Education:			
8 and under	53.1	49.4	52.2
9 to 11	18.8	19.0	18.8
12	18.5	21.0	19.1
1 to 3 yr college	6.8	7.4	6.9
4 yr college and above	2.8	3.3	2.9
Ethnic group:			
White	67.5	80.1	70.5
Black	22.0	16.9	20.8
American Indian	3.4	1.6	3.0
Other	7.1	1.4	5.7
Spanish American	5.6	5.1	5.5
Economically disadvantaged	100.0	100.0	100.0

II. COMPREHENSIVE MANPOWER PROGRAMS AND PUBLIC SERVICE EMPLOYMENT

Older workers also benefit from programs and services established with manpower revenue sharing grants provided to units of State and local government under titles I, II, and VI of the Comprehensive Employment and Training Act (CETA) of 1973. Attached is an official Manpower Administration Report, dated March 19, 1975 and entitled "Characteristics of Enrollees in CETA Title I and Title II Programs." This report reflects the participation rate of persons in the upper age groups under comprehensive manpower programs (CETA title I) and under public employment programs (CETA title II). The report provides a comparison between participation rates among the various age groups and provides a further comparison to manpower programs as they were conducted under the categorical approach in the preceding fiscal year. Statistics for the recently implemented emergency jobs program (CETA title VI) are not yet available.

CHARACTERISTICS OF ENROLLEES IN CETA TITLE I AND TITLE II PROGRAMS

[First ½ fiscal year 1975 compared to similar fiscal year 1974 programs (percentage distribution)]

	CETA title I	Categorical programs, fiscal year 1974[1]	CETA title II	PEP, fiscal year 1974
Total:				
Number	[2]382,800	549,700	[2]60,800	[2]66,200
Percent	100.0	100.0	100.0	100.0
Male	51.2	57.7	64.5	66.1
Female	48.8	42.3	35.5	33.9
Age:				
Under 22	65.2	63.1	23.7	22.8
22 to 44	28.5	30.5	62.4	66.5
45 to 55	3.6	6.2	9.1	10.7
55 and over	2.7		4.8	
Education:				
8 grades or less	13.9	15.1	8.9	22.8
9 to 11	52.8	51.1	20.0	
12 and over	33.3	33.6	71.1	77.2
On public assistance:				
AFDC	15.1	23.4	5.7	10.1
Other	11.9		7.4	
Economically disadvantaged	81.0	85.7	48.6	34.1
Ethnic group:				
White	54.4	54.9	63.5	68.8
Black	39.8	37.0	23.6	22.9
American Indian	1.4	3.5	2.3	3.3
Other	4.4	4.6	10.6	5.0

See footnotes at end of table.

CHARACTERISTICS OF ENROLLEES IN CETA TITLE I AND TITLE II PROGRAMS—Continued

[First ½ fiscal year 1975 compared to similar fiscal year 1974 programs (percentage distribution)]

	CETA title I	Categorical programs, fiscal year 1974[1]	CETA title II	PEP, fiscal year 1974
Spanish American	11.7	15.4	11.6	13.2
Limited English-speaking ability	2.4	INA	7.4	INA
Migrants or seasonal farmworkers	1.2	INA	1.3	INA
Veteran:				
Special Vietnam	4.5	15.3	12.9	39.2
Other	3.7		14.6	
Handicapped	4.0	6.3	3.0	4.2
Full-time student	37.3	INA	3.8	INA
Offender	3.3	INA	2.1	INA
Labor Force:				
Status:				
Employed	2.6	[4] 7.6	1.7	INA
Underemployed	4.6	[4] 8.7	9.2	9.7
Unemployed	55.5	[4] 75.6	81.8	90.3
Not in labor force	37.3	[4] 8.1	7.3	INA
Receiving unemployment insurance	2.1	4.6	6.6	7.4
Median hourly wage of employed terminees:				
Preenrollment	$2.45	$2.30	$2.85	$2.78
Postenrollment	2.70	[5] 2.86	3.39	[6] 2.94

[1] Includes MDTA-institutional, JOP/OJT, NYC in-school, NYC out of school, Operation Mainstream, CEP and JOBS.
[2] Preliminary data; includes an estimate for nonreporting projects.
[3] Excludes enrollees in PEP summer youth program for whom data was not available.
[4] Excludes NYC in-school and JOBS enrollees for whom data was not available.
[5] Includes MDTA-Institutional, OJT, CEP, JOP.
[6] Median wage is for the PEP job; median wage for post-PEP employment is not available.

Note: INA=Information not available.

Source: Office of Administration and Management, Division of Reporting Operations, Mar. 19, 1975.

III. UNITED STATES EMPLOYMENT SERVICE PROGRAM FOR OLDER WORKERS

A. National Employ the Older Worker Week

In fiscal 1975, the United States Employment Service is playing a major role in the observance of National Employ the Older Worker Week, a nationwide campaign which promotes the employment of older workers. In addition to the issuance of guidelines, the national office supervised the preparation of pamphlets, brochures, films, and public service announcements to assist the States in the observance of this "week." This year special emphasis is being placed on an educational campaign to encourage employers to hire older workers.

B. Training and Technical Assistance Contract with the National Council on the Aging

For fiscal 1975, the Manpower Administration has awarded a contract to the National Council on the Aging to provide technical assistance and training in an effort to increase the knowledge and skills of employment service staff involved in interviewing, counseling, and placing middle-aged and older workers. In addition the contract stipulates that in certain States, the National Council on the Aging will provide concentrated and specific technical assistance, training, and information-promotion support to improve services to older workers. The major purposes of such demonstration projects are to (1) substantially impove the overall program of services to older workers, and (2) develop effective measurement tools to reflect the results of such efforts.

C. Industrial Health Counseling Service

During fiscal year 1975, the Manpower Administration funded under contract with the National Council on the Aging the Industrial Health Counseling Service (IHCS). The IHCS implements the Koyl System for appraising physical capacities/job requirements and is designed to demonstrate the effectiveness of the Koyl methodology as a means of helping to refer and place older workers and physically handicapped workers in employment, without regard to age or handicap.

The IHCS (Koyl) system matches a worker's physical capacities to the physical demands of the job. The individual is given an extensive physical examination that assesses his physical work capabilities and the results of this examination are profiled. After completion of this profile, a corresponding job analysis profile is made on a specific job or a series of jobs. Each job is rated in terms of minimum requirements for effective performance; and to the extent possible, the physical profile and the job profile are properly matched for each individual.

Because of the success of the Industrial Health Counseling Service, the Koyl technique is being implemented in three other communities.

SUMMARY OF THE ADMINISTRATIVE AND ENFORCEMENT ACTIVITIES TO IMPROVE AND PROTECT THE EMPLOYMENT OPPORTUNITIES OF OLDER WORKERS UNDER THE AGE DISCRIMINATION IN EMPLOYMENT ACT

U.S. Department of Labor, Employment Standards Administration

SIX YEARS OF ADEA ENFORCEMENT

More sophisticated investigation techniques brought increased results during fiscal year 1974 as substantial age discrimination violations were disclosed, particularly with respect to hiring practices and layoffs. Monetary damages found due ($6.3 million) during fiscal year 1974 were greater than the combined totals for the preceding five years. Income actually restored to employees ($2.5 million during fiscal year 1974) was almost four times that of the previous year.

The number of complaints received during fiscal year 1974 (3,040) was triple the number received during fiscal year 1969 (1,031).

1974 ACTIVITIES

In 1974, the first amendments to the act were passed which extended coverage to an estimated 17 million jobs in Federal, State, and local governments[1] and establishments within 20 or more employees. The scope of the act is currently estimated as affecting approximately 1 million establishments employing 60 million persons.

Some dramatic litigation cases occurred in 1974 which served as a strong reinforcement to administrative efforts. The largest concluded litigation action in 1974 (and to date) was the Department of Labor's suit against Western Operations, Inc., a unit of Standard Oil Company of California, which was settled on the basis of offers of reinstatement to 120 former employees, and the payment of $2 million to 160 former employees. A $20 million age bias suit, the largest in terms of money, was filed in 1974 by the Department of Labor on behalf of some 300 present and former employees of the Baltimore and Ohio Railroad Company and the Chesapeake and Ohio Railway Company. In addition to seeking the reinstatement of employees 40 to under 65 years of age who were unfairly discharged or demoted, the suit seeks the abolition of a mandatory retirement age of 62 included in the railroads' amended pension plan.

Some 47 suits were filed in calendar year 1974. Since the effective date of the act on June 12, 1968, over 225 court actions have been instituted by the Department of Labor.

The major litigation cases, as well as the extension of coverage to more private employers and to most public employment have been accorded widespread publicity by the news media. This publicity has resulted in an increased awareness of the Age Discrimination in Employment Act's application on the part of the general public.

In recent years the thrust of the Age Discrimination in Employment Act's enforcement has shifted to full fact-finding investigations (regular fact-finding investigations of the entire establishment) because such investigations tend to disclose patterns of age discrimination affecting large numbers of older workers. During 1974, the number of such investigations was just under 3,000, an increase of 27 percent over the previous year.

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[1] The 1974 amendments to the ADEA, among other things, amended the definition of "employer" to expand coverage to employees of State and local governments, effective May 1, 1974. It must be noted, however, that the Supreme Court agreed to hear an appeal filed by the National League of Cities, the National Governor's Conference, and 19 States, challenging the constitutionality of these amendments. The case was argued in the Supreme Court on April 16, 1975.

Less formal, time-saving compliance techniques, such as conciliations (attempting to resolve a specific problem through informal conference and persuasion) and compliance contracts (situations that require minimal investigative efforts), accounted for 39 percent of the compliance actions during fiscal year 1974. Section 7 of the Act specifically provides that conciliation be attempted before legal proceedings are initiated. Most of the remaining compliance actions (nearly three-fifths) were either limited or full investigations.

During fiscal year 1974, a total of 7,535 establishments were investigated under the Act. As in the past few years, approximately three-fifths of the establishments investigated were found to be in compliance with all of the ADEA provisions; the other two-fifths were in violation of one or more of the provisions of the act.

Monetary violations amounting to $6.3 million were disclosed in 277 establishments involving 1,648 employees. Income was restored to 637 employees in the amount of $2.5 million in 110 establishments.

Nonmonetary discriminatory practices were found in 2,680 establishments; 2,744 employees were aided, i.e., hired, rehired, promoted, put into a retirement program, etc., and 84,207 job opportunities were made available by the removal of discriminatory age barriers.

Illegal advertising was the most prevalent discriminatory practice disclosed (2,088 instances), followed by refusals to hire (608), and illegal discharges (202).

SUMMARY OF PENSION PLAN TERMINATION INSURANCE PROTECTIONS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Pension Benefit Guaranty Corporation

On September 2, 1974, the President signed into law the Employee Retirement Income Security Act of 1974 (ERISA), which provides many new protections and guarantees for employees covered by private pension plans.

One of the key sections of ERISA, title IV, established the Pension Benefit Guaranty Corporation (PBGC), a self-financed, Government corporation. The Secretary of Labor is the Chairman of the Corporation's Board of Directors; the Secretaries of the Treasury and Commerce are the other Board members.

Upon termination of a covered pension plan (most defined benefit plans are covered), the PBGC guarantees the payment of basic benefits vested under the terms of the plan, within limits specified in ERISA. In the event a plan terminates with insufficient assets, PBGC pays the guaranteed benefits. However, the employer sponsoring the plan is liable to the PBGC for the payments it made, up to 30 percent of the employer's net worth.

For individuals who are not already covered by a pension plan, or for those who are leaving employment under a plan, ERISA permits establishment of tax-qualified individual retirement accounts. PBGC furnishes advice and assistance on the economic desirability of establishing such a program.

In its first six months of existence, PBGC collected about $32 million in premiums. The annual premium, which is paid to the Corporation by each covered plan, is now 50 cents for each participant in a multiemployer plan, and $1 for each participant in a single employer plan. Over 1,100 termination cases were being processed by the end of that first six months.

Through the pension benefit guaranty program, an estimated 26 million workers and retirees have the security of knowing their retirement benefits ae guaranteed by a U.S. Government agency.

ITEM 8. DEPARTMENT OF TRANSPORTATION

February 15, 1975.

Dear Mr. Chairman: In response to your letter of December 20, 1974, I am pleased to send to you the enclosed report which summarizes the major activities of this Department in assisting older Americans during 1974.

If we can assist you further, please let us know.

Sincerely,

John W. Barnum,
Acting Secretary.

[Enclosure]

SUMMARY OF ACTIVITIES TO IMPROVE TRANSPORTATION SERVICES FOR THE ELDERLY

I. INTRODUCTION

Improving transportation for the elderly is an important objective of the Department of Transportation. Below is a summary of relevant 1974 (1) legislative and regulatory activities; and (2) program activities, including research, demonstrations, capital assistance, technology sharing, and interagency cooperation. Where feasible, projected initiatives on behalf of the elderly have been incorporated into the report.

Many of the activities described in this report are directed toward the handicapped explicitly; however, a little more than one-third of the elderly are handicapped and they will also benefit from these initiatives.

II. LEGISLATION AND REGULATIONS

A. LEGISLATION

The National Mass Transportation Assistance Act of 1974 establishes an $11.8 billion, 6-year mass transportation program, for both capital and operating assistance. Section 5(m) of the Act requires that rates charged elderly and handicapped persons during non-peak hours for transportation utilizing equipment and facilities of DOT-funded projects, will not exceed one-half the rate applied to general transit users during peak hours. Formal regulations governing implementation of this provision will be promulgated within the next six months. Implementation of this provision should aid in alleviating the economic constraints which impede the use of transit by many elderly citizens. In addition, it should effectively supplement UMTA's other activities devoted to reducing physical barriers to the use of transit by these individuals.

B. MASS TRANSIT REGULATION

Section 16(a) of the Urban Mass Transportation Act of 1964, as amended, declared as national policy that elderly and handicapped persons have the same right as other persons to utilize mass transportation facilities and services. Section 16(a) also directs that special efforts be made in the planning and design of mass transportation facilities and services so that the availability to elderly and handicapped persons of mass transportation which they can effectively utilize will be assured. The Urban Mass Transportation Administration (UMTA) is preparing to issue a notice of proposed rulemaking which will state UMTA's current requirements for grant applicants in the area of transportation services to the elderly and the handicapped, and will establish new requirements. We expect the rule to require that: (1) all grantees of UMTA planning funds identify the transportation needs of the local elderly population and address these needs as part of the transportation improvement program for the urban area; (2) all transit-related buildings and facilities planned or constructed after the effective date of the rule be accessible to the elderly and handicapped; (3) all new transit rolling stock purchased with capital grants awarded after the effective date of the rule incorporate interior design features that will increase the comfort and convenience of transit vehicles for the elderly. The requirements will take advantage of available technology and hardware to provide handicapped and elderly persons to the maximum extent possible with transportation services they can effectively utilize. This proposed amendment of Chapter VI of Title 49 of the Code of Federal Regulations will add a new Part 600.

C. CURB CUTS

To ensure compliance with Section 228 of the Highway Safety Act of 1973, the Federal Highway Administration issued a Notice on March 8, 1974, to provide guidance to field offices concerning planning and engineering reviews and details for curb ramp construction at pedestrian crosswalks and other provisions, "to provide adequate and reasonable access for the safe and convenient movement of physically handicapped persons." Those elderly who are limited in mobility are expected to benefit from the installation of curb ramps.

A Notice is being prepared to clarify the fact that the curb ramp provisions applies to all crosswalks constructed with Federal-aid funds approved for construction after July 1, 1976, and where feasible on projects approved for construction prior to that date. Highway Safety Program Standard No. 12 is being modified to include this requirement.

D. AVIATION

A Notice of Proposed Rule Making (NPRM) was issued on July 2, 1974, directed toward providing uniform criteria for transportation of mobility-restricted persons by civil air carriers. The Federal Aviation Administation (FAA), received over 1500 individual comments and 200 congressional inquiries relating to the NPRM. A decision will be made in early 1975 whether to isssue a final rule or an amended NPRM on this subject.

E. RURAL PUBLIC TRANSPORTATION

The Federal Highway Administration (FHWA), in cooperation with UMTA, issued regulations concerning the Rural Highway Public Transportation Demonstration Program on November 6, 1974. The project selection criteria developed for this program are intentionally broadly defined to encourage applicants to develop as comprehensive a program as possible to include all the transportation disadvantaged in the specific area. However, the program recognizes the disproportionately high percentage of elderly people living in rural areas. Consequently, one of the selection criteria will evaluate specifically the "adaptability of systems to the needs of the elderly and handicapped." These needs are not limited to the "physically accessible" category (represented by such things as convenient handgrips, low steps, wider doors, stairwell lighting, handy fareboxes, wheelchair lifts, etc.) but also include the needs of the residents to travel to employment locations, medical centers, shopping areas, etc. The guidelines for this program were developed in cooperation with other Federal agencies, including the Administration on Aging, and the project selection procedure will incorporate comments from these agencies, as appropriate.

III. PROGRAM ACTIVITIES

A. RESEARCH AND EVALUATION

1. *Urban Transportation*

(a) A cost/benefit study of four alternative transit services for the elderly and handicapped has been conducted by the Department's Transportation Systems Center (TSC). The four are taxi, special dial-a-ride, specially-equipped standard urban transit bus, and rapid rail.

(b) TSC is conducting a second study that is designed to yield definitive information about the benefits and costs of (1) modifying existing and new transportation systems (air, rail, auto, and public mass transportation) to make them accessible to the physically handicapped and elderly; and (2) instituting specialized services to supplement existing systems, including provision of special private transportation.

(c) A study is being performed by Franklin Institute on "Physical Barrier-Free Transit for the Handicapped and Elderly." The objective of this project is to identify and evaluate all available off-the-shelf hardware which may facilitate the use of public transit systems by the handicapped and elderly.

(d) A project to review and analyze existing and potential circulation aids for provision of access to above and below grade rapid transit systems is now underway. This project will also identify and assess the alternative methods of achieving barrier-free access to rapid transit systems.

(e) Under UMTA's university research program, Southern University is developing a research paper on "The Transportation Problems of the Aged and Handicapped: The Baton Rouge Experience." The investigation proposes to determine the major economic, social and related characteristics of this group and to recommend a transit program based upon the analysis of cost, trip purposes, and time and convenience factors.

(f) A research contract awarded to study the potential for flexible taxi services will investigate a number of services of real and potential aid to the handicapped and elderly. The study will draw upon existing experience and suggest new approaches in order to synthesize a more complete and more flexible taxi service structure. Among the components of this structure will be methods and practices which will enable taxi operators to more effectively serve, and thereby attract, handicapped and elderly patronage.

(g) In conjunction with the preparation of the "General Needs Study for Urban Dwellers," a special study dealing with the specific needs of the elderly and handicapped is being prepared.

(h) A formal invitation for proposals has been issued for a major study entitled "Research on Transportation Problems of the Transportation Handicapped." The objective of this study is to determine the travel requirements of various classifications of handicapped persons to develop and evaluate transportation service alternatives for satisfying those requirements. The elderly population which is also handicapped is part of the target group to be addressed in this study.

2. *Air Transportation*

FAA has completed the initial phase of a study which assessed the effects of the physically handicapped aboard an aircraft during emergency evacuation. This initial study will be supplemented with additional information using live subjects with real disabilities rather than models and individuals simulating disabilities. The latter activity is expected to be completed by mid-1975.

3. *Pedestrian Travel*

Provisions for elderly and handicapped persons are one feature of a nearly completed pedestrian study supported by FHWA.

In an FHWA supported study entitled "Provisions for Elderly and Handicapped Pedestrians," data collection has begun in five selected cities to assess the problems experienced by these groups. A second phase will be a countermeasure evaluation program. Many local communities have indicated strong interest in participating in the evaluation program.

4. *Transportation Safety*

Under the State and Community Highway Safety Program of the National Highway Traffic Safety Administration, projects to benefit the elderly were conducted in ten States in 1974 (Vermont, New Jersey, New York, West Virginia, Minnesota, Wisconsin, Michigan, Illinois, Missouri and Nevada). The projects included instructional programs for senior citizens in highway safety, planning elderly pedestrian safety programs, driver improvement programs for the elderly, special courses about the elderly, and traffic safety for students in driver education instructor preparation programs, driver simulators for the elderly, and audio-visual aids for the elderly.

A driver manual supplement for the elderly is being developed and will be tested in 1975. In addition, a new vision tester is now being built which will be used in research to investigate the visual problems of the elderly during 1976.

5. *Rail Transportation*

The special needs of the elderly and handicapped continue to receive attention at the Federal Railroad Administration test center in Pueblo, Colorado. A major activity of the center is the testing of the capabilities of conventional and advanced design passenger equipment.

6. *Rural Transportation*

A draft report titled "The Use of Existing Facilities for Transporting Disadvantaged Residents of Rural Areas" is undergoing final review and comments by the Federal Highway Administration. Volume I of this two-volume study is a guide for local government officials and developers of rural transportation systems, and covers a broad range of alternatives available to improve the mobility of the rural disadvantaged, including the elderly and physically handicapped. The second volume is a research report containing detailed information on implementation.

B. HARDWARE DEVELOPMENT

Three ongoing programs which should prove beneficial to elderly persons with limited mobility are as follows:

1. The Urban Mass Transportation Administration supported Transbus program has progressed to the stage that three prototype vehicles, which are specially equipped with experimental hardware to board and unboard wheelchair patrons, are being tested by handicapped users in selected metropolitan areas throughout the country. The prototype testing is expected to end in late 1975, and a performance specification for a level change device (lift, ramp) will be developed concurrently, if no unforeseen problems arise during the testing period. The development of this performance specification will accelerate the

availability of a new generation of vehicles that are accessible to elderly and handicapped persons. It is hoped that these vehicles are available in production quantities by 1978. Pending the development of workable performance specifications, UMTA will determine whether to require that all buses purchased with UMTA funds should conform to the specifications for a level-change device and a low floor.

2. The objectives of the project entitled "Low-Pollution Para-Transit Vehicle," is to develop a vehicle well-suited for use in para-transit, particularly in taxi service. The contract provides for design and fabrication of one prototype vehicle that can transport up to five ambulatory passengers and that can be modified easily to carry one wheelchair and two ambulatory passengers.

3. A contract has been awarded for the "Small Bus Requirements, Concepts, and Specifications" program. The purpose of the Small Bus Project is to: (a) examine small bus operations and projected desired operations in the United States; (b) establish needed and desired operating features for small buses; (c) determine desirable features for accommodating the special needs of the elderly and handicapped, including wheelchair travelers; (d) produce conceptual small bus designs to meet the operating features; and (e) establish a performance standard for a small bus suitable for mass transit service in the United States.

C. SERVICE DEVELOPMENT

The Service Development program of the Urban Mass Transportation Administration will continue in fiscal year 1976 and fiscal year 1977 at approximately the fiscal year 1975 funding level of $3.25 million. About seven projects per year will be directed toward demonstrating and evaluating innovative service concepts for the elderly and handicapped. Of the seven demonstration projects now underway, two will close out this fiscal year, two will have reduced UMTA funding support in fiscal year 1976, and three will continue with full UMTA funding support. At least three new demonstration projects will be initiated during fiscal years 1975 and 1976, with the respective objectives of (1) experimenting with user-ride subsidies to determine how the travel patterns of the subsidized groups are affected; (2) initiating in a large city a transportation service for the elderly and handicapped that is coordinated with health and social service agencies; and (3) applying information obtained in previous small city demonstrations to a medium-size city.

D. CAPITAL ASSISTANCE

The 1973 Federal-Aid Highway Act amended the UMTA Act (Section 16(b)(2)) and resulted in $20.M being set aside from the Capital Assistance Program to provide capital grants to private, nonprofit corporations and associations for transportation for the elderly and handicapped. The Administrator of UMTA has asked each Governor to assist in administering this program by (1) designating a State agency to handle the program, preferably the State Department of Transportation, and (2) developing project evaluation and selection criteria (which must be approved by the Urban Mass Transportation Administrator). When these two requirements are fulfilled, the States may then submit applications to the proper UMTA officials in Washington, under greatly simplified procedures.

The application deadline for fiscal year 1975 funds is April 15, 1975. At this time no final applications have been submitted to the Urban Mass Transportation Administration and UMTA is unable to determine how many projects will be funded this year. The funding level for this program is expected to remain at about $20 million for fiscal year 1976 and 1977.

In addition to the above, a total of twenty-one projects which provide features for the non-ambulatory handicapped have been funded by UMTA. These have included four ferry boats at a total cost of $17,666,480; and 63 buses of various sizes at a total cost of $2,619,700.

E. TECHNOLOGY SHARING

In September 1974, the DOT Technology Sharing Program issued its first summary state-of-the-art document, focusing on the role of and promise for demand-responsive bus systems. As is well known by now, these systems are very effective options to meet the local travel needs of the mobility limited. The document was drafted through the facilities of the Department's Transportation Systems Center's Technology Sharing Program Office. It has been revised based on State and local comments received at a workshop held during June 1974, in Philadelphia, Pennsylvania. This workshop was co-sponsored by the Secretary of Transportation's Office of R&D Policy and the UMTA Office of Transit Management. Some 3,000 copies of the document have been requested to date, and queries for further information continue to come in. The workshop sessions were videotaped, and a summary overview tape is also being disseminated.

The Technology Sharing Program has prepared a preliminary outline of a proposed rural transportation state-of-the-art document. A final validated document is expected to be completed by July 1975. In addition, UMTA may sponsor a conference on the entire area of handicapped and elderly transportation problems in conjunction with the Transportation Systems Center Technology Sharing Program office.

F. INTERAGENCY COOPERATION

The Federal Railroad Administration has continued to cooperate with the marketing and operating departments of Amtrak to assure that new equipment design and new or renovated terminals include methods to facilitate movement of mobility limited individuals. In an engineering design study of a contemplated new metroliner train station in New Carrollton, Maryland, the contractor has specific responsibility to include methods of easing the transportation problems of the mobility limited.

Personnel from DOT have worked closely with personnel from the Administration on Aging in the development of the report to Congress on the state-of-the-art of transportation for the elderly. This report is required under Title IV, Section 12, of the Older Americans Act.

The Department of Transportation and the Administration on Aging signed a working agreement aimed at assuring maximum coordination and mutual support between the programs of the Department of Transportation and the Administration on Aging. The agreement sets forth the UMTA objective of providing capital grants and loans to private nonprofit corporations and associations to assist them in meeting the special transportation needs of the elderly and handicapped for whom mass transportation services are otherwise unavailable, insufficient, or inappropriate. From the standpoint of the Administration on Aging, the agreement aids in facilitating the implementation of its programs by helping to provide transportation services for the elderly as part of a coordinated comprehensive delivery system.

The Department of Transportation and the Department of Housing and Urban Development signed a working agreement aimed at increasing the mobility of the elderly and handicapped living in HUD-assisted housing. The agreement, which is being circulated to all Federally assisted housing projects and to DOT field staff, is aimed at improving utilization of Federal Highway Administration and Urban Mass Transportation Administration programs to assist these persons.

ITEM 9. DEPARTMENT OF THE TREASURY

FEBRUARY 20, 1975.

DEAR MR. CHAIRMAN: On behalf of the Secretary of the Treasury I am furnishing you with a summary of significant activities benefiting the elderly. This summary describes work being done by the Internal Revenue Service and the Bureau of Government Financial Operations.

We in the Department of the Treasury are continuing to make assistance to the elderly a priority program. Efforts in this area involve not only improvements in the delivery of services, but also the formulation of legislative proposals to simplify the burdens imposed on the aged and retired populations.

If I can provide additional assistance to the Committee, please let me know and I shall be more than happy to furnish it.

With kind regards,

Sincerely,

DONALD C. ALEXANDER, *Commissioner.*

[Enclosure]

INTERNAL REVENUE SERVICE ACTIVITIES AFFECTING THE AGED

The Internal Revenue Service has for some time been concerned with an emphasized providing the elderly with tax assistance. In 1974 the Service was active in several areas directly associated with providing assistance:

—Conducted as part of the general Voluntary Income Tax Assistance Program (VITA) a tax aide volunteer program focused on the elderly and retired. The program was conducted in cooperation with the Institute of Lifetime Learning and the National Retired Teachers Association.

—Provided material to the Institute of Lifetime Learning with specific instructions about the Retirement Income Credit and other topics of special interest to the elderly.

—Assisted community colleges in developing adult education programs relating to tax benefits for senior citizens and the preparation of tax returns.

—Conducting two day institutes to over 5,000 senior citizens, who in turn assisted approximately 145,000 elderly and retired taxpayers.

—Emphasized in the Taxpayer Service Representative (TSR) training topics of concern to older Americans, such as Retirement Income Credit, taxability of pensions and annuities, additional exemptions for age, and sales of personal residences. Also included was extensive training on the preparation of Schedule E (reporting of pension and annuity income), 1040ES (estimated tax return filed by many elderly taxpayers with fixed incomes from which no taxes are withheld), and Schedule R (Retirement Income Credit).

The Revenue Service also has designed an individual tax return in line with legislative proposals for tax simplification. The simplified return would be particularly helpful for elderly taxpayers, but implementation would of course require enactment of the legislative proposals. In the interim the Service is examining the feasibility of a separate tax return package for the elderly.

New efforts to assist the retired and elderly in 1975 include:

—Additional emphasis in the TSR training program in assistance to the elderly, including a special review session on tax benefits available for senior citizens.

—Designation of taxpayer assistance to the elderly as a special emphasis program, which involves districts making special effort to assist the elderly.

—Provision for additional taxpayer assistance in areas of the community with high concentrations of elderly residents. This entails dispatching TSR's to nursing homes, hospitals, leisure world locations, state welfare offices, and Social Security offices.

—Work with the Social Security Administration to develop a comprehensive approach to the problems of the elderly and retired.

BUREAU OF GOVERNMENT FINANCIAL OPERATIONS ACTIVITIES AFFECTING THE AGED

The Bureau in 1974 participated in two significant programs involving the elderly:

—Implemented in conjunction with Social Security a pilot program by which Social Security beneficiaries may receive their payments by credit to their accounts in financial institutions. Such a system virtually eliminates loss, theft, forgery, and delays in receiving credit when the beneficiary is away from home. Extension of the pilot is now underway with nationwide implementation scheduled by the fall of 1975, and plans are underway to afford this direct deposit option to other elderly check recipients.

—Issued Supplementary Security Income (SSI) checks on distinctive yellow stock to facilitate negotiation and priority processing. This also facilitates issuance of substitute checks to claimants on an expedited basis.

ITEM 10. ACTION

FEBRUARY 7, 1975.

DEAR MR. CHAIRMAN: In response to your request of December 20, 1974, I am enclosing a report summarizing ACTION's activities for Older Americans.

Please let me know if additional information is needed on any of our Volunteer programs.

Kind personal regards.

Sincerely,

CARLTON KAMMERER,
Assistant Director of ACTION, Congressional Affairs.

[Enclosures]

DOMESTIC VOLUNTEER PROGRAMS

VOLUNTEERS IN SERVICE TO AMERICA (VISTA)

Volunteers in Service to America (VISTA) was originally authorized under Title VIII, Section 801, of the Economic Opportunity Act of 1964, as amended. The Program was transferred to ACTION in July 1971. It is now authorized under Title I, Part A, Section 101 of the Domestic Volunteer Service Act of 1973.

In fiscal years 1973 and 1974 approximately 11 percent of all VISTA Volunteers worked on projects geared specifically toward services to older people. Many other VISTA projects, though not directed solely toward the elderly, impact significantly on the problems of the aged.

Other VISTA Volunteer activities in which older persons are among those receiving benefits include health-related services such as food and nutrition, housing, legal services, welfare assistance and referral services.

Approximately 10.8 percent of the VISTA Volunteers serving as of January 1, 1975, are 55 years of age and older. The breakdown is as follows:

55 to 59	122
60 to 64	114
65 to 69	163
70	41
Over 70	79
Total	519

These older Volunteers work in a variety of programs across the VISTA spectrum. We anticipate approximately the same effort for fiscal year 1975.

THE FOSTER GRANDPARENT PROGRAM (FGP)

The Foster Grandparent Program (FGP) provides opportunities for low-income persons, age 60 and over, to offer supportive person-to-person Volunteer services in health, education, welfare, and related settings to children with special needs.

The Program was originally developed as a cooperative effort between the Office of Economic Opportunity and the Department of Health, Education, and Welfare (Administration on Aging). It was given a legislative basis in 1969 under Title VI, Part B, of the Older Americans Act of 1965, as amended. In July 1971 the Program was transferred to ACTION in accordance with Executive Reorganization Plan No. 1. Current authorizing legislation is Title II, Part B of Public Law 93-113, the Domestic Volunteer Service Act of 1973.

The Foster Grandparent Program is designed to meet the needs of two groups: the low-income aging and children with physical, mental, social or emotional health needs. This activity is intended to enable older persons to maintain a sense of personal growth and self-worth, to enrich social contacts and retain physical and mental alertness. Foster Grandparents do not displace salaried staff, but complement staff care to special children with the love and personal concern essential to their well-being.

ACTION grants to support the operation of Foster Grandparent Programs are awarded to public or private non-profit agencies and organizations except program settings where Foster Grandparents serve. These settings include institutions for the mentally retarded; correctional facilities; pediatric wards of general hospitals; schools, day care centers, private homes; and institutions for physically handicapped, emotionally disturbed and dependent and neglected children. Foster Grandparents serve four hours a day, five days a week, and receive a small stipend for their service. They are also reimbursed for, or provided with, transportation and, where possible, are provided a nutritious meal daily. They are covered by accident insurance and receive annual physical examinations. An orientation and in-service training program is provided; and through the professional staff of each program, Foster Grandparents receive counseling on personal matters and information and referral services.

In fiscal year 1974, with an appropriation of $25 million, the Foster Grandparent Program expanded from 150 to 156 local programs in 50 states, Puerto Rico, the Virgin Islands, and the District of Columbia. This growth will permit 12,200 Foster Grandparents to serve 24,000 children each day. During fiscal year 1975 ACTION expects to maintain the current project and Volunteer strength.

In a recent survey of over 950 Foster Grandparents, 95% of the Volunteers reported improved "satisfaction with life"; 94% reported improved "feeling of usefulness to others", and 92% reported improved "happiness" and "less financial worry." In addition, 75% of those Foster Grandparents queried reported that the Foster Grandparent Program was one of the most important events to occur during the past five years of their lives.

In many instances the Foster Grandparent Program offers to the children served an opportunity to participate more fully in the activities and joys of life. One Foster Grandparent, a retired typist, has helped a severely retarded cerebral palsy victim learn how to walk for the first time in his thirteen years. Another Foster Grandparent has taught a blind and hydrocephalic child to feed himself and talk; as a result of the Grandparent's efforts, the boy, who had not been home for years, is now able to visit at home for extended periods of time. And Jim, a child with severe hearing impairment and no speech, has been transformed from a withdrawn, silent loner into a curious, expressive boy able to communicate in sign language, thanks in part to the efforts of his Foster Grandparent. Numerous other examples attest to the ability of Foster Grandparents to train the "untrainable" and give reason for hope to the "hopeless."

The Foster Grandparent Program has provided many insights ito the potential utilization of the elderly in community settings by demonstrating that older persons have the talent, skills, experience, and desire to serve their communities. This desire to serve was expressed repeatedly by older persons at the 1971 White House Conference on Aging. The Conference Section on Retirement Roles and Activities established this need as a national priority.

SERVICE CORPS OF RETIRED EXECUTIVES (SCORE)

The Service Corps of Retired Executives (SCORE) is a Volunteer program that links retired businessmen and women who have management expertise with the owners/managers of small businesses and community organizations that need management counseling. Since SCORE began in 1965, it has responded to more than 250,000 requests for assistance and in fiscal year 1974 handled more than 43,000 management counseling cases. It is sponsored by ACTION and the Small Business Administration.

There are now approximately 5,000 SCORE Volunteers serving in all 50 states, the District of Columbia, and Puerto Rico. SCORE Volunteer growth has resulted in the formation of more than 250 chapters across the country.

SCORE Volunteers work in their home communities. There are very few forms of private enterprise that have not received their assistance. To name a few: grocery and drug stores, restaurants, hardware stores, fast food franchisees, repair shops, dry cleaners, clothing stores, truckers, laundries, and a wide variety of small manufacturers. SCORE counseling is especially helpful to those persons considering going into business.

Volunteers in this program provide their services without charge, but are reimbursed for out-of-pocket expenses.

THE SENIOR COMPANION PROGRAM (SCP)

The purpose of the Senior Companion Program is to provide meaningful opportunities for low-income persons, age 60 and over, to offer person-to-person supportive services to adults, especially older persons, living in their own homes and in residential and non-residential group care facilities.

The Senior Companion Program, an Older Americans Community Service Program, was originally authorized under Title VI, Part B, of the Older Americans Comprehensive Services Amendments of 1973. Current authorizing legislation is Title II, Part B, of Public Law 93–113, the Domestic Volunteer Service Act of 1973.

The Senior Companion Program became operational in fiscal year 1974 and there are now 18 demonstration projects established nationwide with 750 Senior Companions as of December 31, 1974.

The Senior Companion Program, like the Foster Grandparent Program, primarily benefits low-income older persons. It provides them with opportunities through Volunteer service to maintain a sense of self-worth, retain physical and mental alertness, and enrich social contacts. Additionally, the program's provision of a stipend and other direct benefits enable them to partially overcome the combined hardships of poverty and old age.

ACTION grants to support the operation of Senior Companion Programs are awarded to public and private non-profit agencies and organizations. Volunteer Stations where Senior Companions serve include hospitals, nursing homes, intermediate care facilities or home for the aged, various health, welfare or related settings in a community.

Senior Companions serve four hours a day, five days a week, and receive a small stipend for their service. They are also reimbursed for, or provided with, transportation and, where possible, a nutritious meal daily. They are covered by accident insurance and receive annual physical examinations. An orientation and in-service training program is provided; and through the professional staff of each project, Senior Companions receive counseling on personal matters and information and referral services.

In fiscal year 1974 ACTION awarded grants totalling $2.4 million to establish the 18 pilot projects to support the services of approximately 1,000 Senior Companions who, in turn, will serve approximately 3,000 to 4,000 adults. The persons served are primarily older persons with special needs. During fiscal year 1975 ACTION shall continue to support the 18 demonstration projects.

THE RETIRED SENIOR VOLUNTEER PROGRAM (RSVP)

The purpose of the Retired Senior Volunteer Program is to develop a recognized role in the community and a meaningful life in retirement for older adults through significant Volunteer service.

Originally authorized under the Older Americans Act Amendments of 1969, RSVP became operational in 1971 when the Department of Health, Education, and Welfare (Administration on Aging) funded eleven pilot projects. In July 1971 the Program was transferred to ACTION in accordance with Executive Reorganization Plan No. 1. Current authorizing legislation is Title II, Part A of Public Law 93-113, the Domestic Volunteer Service Act of 1973.

ACTION grants are awarded to local public agencies and nonprofit private organizations to support the development and operation of RSVP's providing Volunteer opportunities for persons 60 years of age and over. Either transportation, or assistance with the costs of transportation, is provided between the homes of senior Volunteers and their Volunteer Stations. When senior Volunteers serve over a meal hour, meals are available without cost to them at many Volunteer Stations. Accident insurance is provided for all RSVP Volunteers.

As an inherently local program, each RSVP is locally planned, operated, controlled, and supported. Federal funding is provided on an annually decreasing basis for the first 5 years of a local project's operation. According to legislation enacted July 12, 1974 (P.L. 93-351 amending Section 201 of P.L. 93-113), sponsors are generally expected to meet locally 10% of the cost of the project in the first year of operation, 20% in the second, 30% in the third, 40% in the fourth, and 50% in the fifth. Exceptions to this requirement may be granted by ACTION in individual cases of demonstrated need.

Retired Senior Volunteer Programs encourage organizations and agencies to develop a wide variety of Volunteer opportunities for retired persons. The focal point of RSVP activity is the needs and interests of the senior Volunteer, and Volunteer opportunities are arranged to match his interests, abilities, and physical capacities. Orientation or instruction for Volunteer assignments may be provided. Older adults, including the isolated elderly, are sought out and actively encouraged to contribute their time and experience in service to their communities. Handicapped older persons are included in the ranks of senior Volunteers; special arrangements to facilitate their service are made when necessary. There are no income, education, or experience requirements for a retired person to become a senior Volunteer.

Special assignments arranged for senior Volunteers offer varied opportunities to serve people of all ages. Assignments are made to publicly owned and operated facilities or projects, and to local programs sponsored by private nonprofit organizations. Examples are schools, courts, libraries, museums, hospitals, nursing homes, day care centers, institutions, and programs for shut-ins.

In the last 3 years the Retired Senior Volunteer Program has experienced truly dramatic growth. In the latter 6 months of Fiscal Year 1973 alone, the Program more than doubled in size to total 590 local RSVP's. These programs are located in all fifty states, Puerto Rico, the Virgin Islands, and the District of Columbia. Almost 65,000 senior Volunteers were in service by the close of Fiscal Year 1974. Program strength increased to 666 by June 30, 1974. That approximate number of programs is expected to be maintained while the number of Volunteers continues to increase to a projected 140,000 by the close of Fiscal Year 1975.

In December 1973, E. F. Shelly and Company, Inc., completed a study of the Retired Senior Volunteer Program. The study identified benefits derived from participation in RSVP by both senior Volunteers and Volunteer Stations. Nearly three-fourths of the Volunteer Stations included in the study indicated that senior Volunteers provided a valuable supplement to their staff, and nearly two-thirds stated that they would be forced to cut services or activities in the absence of senior Volunteers.

More than half of the senior Volunteers included in the study indicated that they felt better physically, and nearly four-fifths stated they felt better mentally, due to their Volunteer experience. In addition, study data indicated that a majority of senior Volunteers lived alone and had little or no previous Volunteer experience; they, therefore, experienced an increase in community involvement and a reduction in isolation as a result of RSVP.

Numerous examples illustrate the value of the contributions of senior Volunteers to their communities. A nurse writes, "All of the senior Volunteers' achievements and contributions aid us in promoting the effectiveness and operation of our hospital in a more advantageous manner." The Director of Education at a State correctional school writes, "Three of our former students . . . were all tutored by RSVP Volunteers and the three all said they would not have finished high school or passed the high school equivalency test without this help" The Director of two day care centers writes, "Because of the senior citizens, we have been able to provide an additional area of enrichment for our children in the centers." And the managing attorney of a legal services program writes, "Because of the RSVP Volunteers . . . and the competent and gracious assistance they are giving to us, we are able to serve a much larger number of clients in a much more professional atmosphere than would ever be possible in their absence." Countless other examples affirm that senior Volunteers are serving their communities, and serving them well, in a variety of Volunteer activities.

A major thrust of the Program in fiscal years 1975 and 1976 is to place many additional senior Volunteers in public schools, in connection with the nation's Bicentennial observance, to pass on to the youth in the schools the Volunteers' personal experiences in the development of our national heritage.

INTERNATIONAL OPERATIONS

While the Peace Corps is not designed to impact upon the aging in the United States, its mission overseas provides some unique opportunities for the older American. During its recent past, there have been changes in the degree of skill required for overseas service. The older person in our society is more likely to have the kind and level of skill needed by many of the countries in which we operate, and therefore, we pay particular attention to that group in our recruiting efforts.

Our most recent figures as of 30 September 1974, indicate that about 4% of our Volunteers and trainees are over age 50. The specific figures follow:

Volunteers	7,027
Volunteers over 50	285
Volunteers over 60	150
Percentage over 50	4

ITEM 11. ARCHITECT OF THE CAPITOL

FEBRUARY 11, 1975.

DEAR SENATOR: I am pleased to transmit herewith a statement describing the major activities of this office during 1974 relating to the aging, in accordance with the request contained in your letter of December 20, 1974.

As you know, I have undertaken a thorough study of existing architectural barriers to the handicapped in the Capitol Buildings and Grounds and have removed those barriers where such action could be accomplished within existing operating and maintenance funds by our existing personnel. These are the activities summarized in the enclosure.

An Appropriation covering costs of removal of the remaining barriers has been requested for Fiscal Year 1976.

I shall, of course, be pleased to provide any other information you may deem desirable.

Cordially,

GEORGE M. WHITE,
FAIA, Architect of the Capitol.

[Enclosure]

1974-75 ACTIVITIES RELATING TO THE AGING

On March 15, 1974, the Architect received the Report entitled "Architectural Barriers in Buildings and Grounds Under the Jurisdiction of the Architect of the Capitol" prepared by Edward H. Noakes, AIA, consultant to the Architect and specialist in barriers to the handicapped.

This report was undertaken in pursuance of the Architect's responsibilities for structural and mechanical care of the buildings in accordance with law and in conformance with Public Law 90-480.

Upon receipt of the Report, the Architect distributed that portion of the Report pertaining to each building to the respective officials responsible for their structural and mechanical care, with his request for an analysis of what items in the Report could be accomplished by employed personnel and within annual maintenance appropriations. Following this analysis, these officials were asked to accomplish these items, giving priority to providing in each building a minimum of one barrier-free entrance, one barrier free toilet for each sex, one accessible drinking fountain, and one accessible telephone. In fact, far more than the minimum has been achieved, though a great many other items requiring appropriations, remain to be done.

For example, of the 37 elevators recommended for adaptation for the handicapped by the consultant, 25 were scheduled for routine modernization in 1974-75, which was expanded, without additional cost, to include facilities for the handicapped. In addition, the Superintendent of the Senate Office Buildings was able to provide three barrier free toilet rooms for each sex in each building.

An appropriation covering costs of removal of the remaining barriers has been requested for fiscal year 1976.

ITEM 12. CIVIL AERONAUTICS BOARD

JANUARY 22, 1975.

DEAR MR. CHAIRMAN: This is in reply to your December 20 letter requesting the Board to submit a report summarizing any major Board activities concerning the aged or aging during 1974, including any plans for such activities during 1975.

In the exercise of its responsibilities under the Federal Aviation Act, the Board takes many actions affecting all segments of the population, including elderly persons. However, during 1974 the Board has not been involved in any major activities specifically concerning the aged or aging, and it appears that there are no proposals for any major activities during 1975 that relate particularly to the aged or aging.

We appreciate receiving a copy of the Report of the Special Committee on Aging and have forwarded the volume to our library for cataloging.

Sincerely,

RICHARD J. O'MELIA, *Acting Chairman.*

ITEM 13. CIVIL SERVICE COMMISSION

FEBRUARY 14, 1975.

DEAR MR. CHAIRMAN: This is in response to your letter of December 20, 1974, requesting a summary of major Civil Service Commission activities related to aging during 1974.

Enclosed is our report on these activities. The report covers significant developments affecting older Americans' rights and benefits in the areas of Federal employment and retirement. Our related efforts during 1975 will focus primarily on (1) further development of programs to assure nondiscrimination in Federal employment on account of age and (2) the provision of services and assistance related to administration of the Civil Service Retirement System and the Retired Federal Employees Health Benefits Program.

We hope that our report will be useful to the Special Committee on Aging in the preparation of its 1974 report. If any additional information is needed, please let us know.

Sincerely yours,

BERNARD ROSEN, *Executive Director.*

[Enclosure]

MAJOR 1974 ACTIVITIES OF THE CIVIL SERVICE COMMISSION AFFECTING RIGHTS AND BENEFITS OF OLDER AMERICANS

AGE DISCRIMINATION IN EMPLOYMENT ACT (ADEA) PROGRAM

There has long been a Federal personnel policy against discrimination on account of age. That policy was strengthened significantly in 1974 by the force of law. Effective May 1, 1974, Public Law 93-259 amendments to the Age Discrimination in Employment Act of 1967 (ADEA) extended coverage of the Act to include the Federal employment sector. The ADEA now requires that all Federal personnel actions shall be made free from any discrimination based on age, except where the Civil Service Commission determines that age is a bona fide occupational qualification (BFOQ) necessary to performance of the duties of a position. The Commission has recognized no BFOQ exception to date. There are a few occupations for which the Congress through other legislation has permitted exceptions to the general prohibition against setting age limits. These are park police, air traffic controllers, and law enforcement and firefighter personnel (see 5 USC 3307).

The Civil Service Commission is responsible for administering and enforcing the ADEA for the Federal civilian service. New regulations issued by the Commission became effective as of May 1, 1974, and were published in the Code of Federal Regulations July 2, 1974 (39 FR 24351). Under these regulations, Federal agencies are required to establish a continuing program to assure nondiscrimination in employment on account of age. A major change instituted under the ADEA was the extension to Federal employees and applicants who are age 40 to less than 65 of the full benefits of administrative procedures in the discrimination complaints system established under the Commission's equal employment opportunity (EEO) regulations. This includes an initial EEO counseling stage to attempt informal resolution; a formal complaint stage with full investigation, opportunity for a hearing, and a decision by the agency head or designee; right to appeal the agency decision to the Civil Service Commission; and appropriate remedial action, such as appointment, promotion or restoration of an employment benefit, when there is a finding of discrimination. Under the law, individuals with complaints of age discrimination also have access to the courts. Although this is still a fairly new area, age discrimination complaints constitute close to 10 percent of the discrimination complaint activity in Federal employment, and these cases are being processed expeditiously to assure full due process to complainants.

In addition to the publication of regulations and discrimination complaints activity, the Civil Service Commission is taking a number of steps to assure that the legal prohibition against discrimination on account of age is incorporated where appropriate as a factor throughout the Federal personnel system. These include revisions in various personnel regulations, Federal Personnel Manual materials, and other publications and issuances. Age has been added as a factor for the onsite equal employment opportunity review agenda of Commission staff who evaluate Federal agency personnel management activities. Through our manpower information systems activity, we are developing a data program which, when completed, will provide us regularly with age-related statistics on Federal employment.

As might be expected in a new regulatory program area, a variety of issues have developed which require interpretation or clarification. Where appropriate, we will issue further specific instructions or guidance to agencies. As an example of enforcement action under the ADEA, the Commission recently required a Federal agency to discontinue its practice of placing persons eligible for optional retirement (who were thus in the age group protected by the law's prohibitions) in a disadvantageous priority category under a placement program for employees displaced in staff reductions.

Because nondiscrimination on account of age is not a new Federal personnel policy, we do not believe major adjustments need to be made in our prescribed personnel systems. However, we do see the emergence of law in this area as an important new dimension in terms of enforcement of the rights of individuals.

CIVIL SERVICE ANNUITANTS

Implementation of P.L. 93–273 (enacted April 26, 1974): This law became effective on August 1, 1974, and has two major provisions. First, it establishes a minimum Civil Service annuity equal to the smallest Social Security "primary insurance amount" rounded to the next dollar. Second, it provides an increase in all annuities based on a separation from Federal service before October 20, 1969 ($20 a month to employee annuitants, and $11 a month to survivor annuities to spouses).

The Commission completed an unclaimed benefits project begun last year. The project attempted to identify and locate former Federal employees over age 62 with at least $50 in the retirement fund in order to determine their possible entitlement to benefits under the Civil Service Retirement Act. A search was made of about 15 million records, resulting in location of 101,337 records representing eligible former employees who had $50 or more in the retirement fund.

From these records, further investigation produced 36,782 addresses of individuals entitled to receive money from the fund. So far, the search has led to payment of 7,367 refund or death claims totaling $1,427,320. In addition, more than 2,000 annuity claims have been or are being processed.

Pursuant to 5 U.S.C. 8340(b), annuities payable under the Civil Service Retirement Act were increased twice, by 6.3 percent effective July 1, 1974, and by 7.3 percent effective January 1, 1975. This section of the retirement law authorized the automatic adjustment of civil service annuities when the cost of living nationwide rises at least 3 percent and stays up for 3 consecutive months. This serves to maintain the purchasing power of civil service annuities.

LIBERALIZATION OF SURVIVOR ANNUITANT PROVISIONS

Implementation of Public Law 93–260, (enacted April 9, 1974): The law reduces the length of marriage requirement for entitlement to a survivor annuity from 2 years to 1 year immediately prior to death.

Implementation of Public Law 93–474 (enacted October 26, 1974): This law establishes, for annuities that had been reduced because of survivor coverage election, restoration of full annuity upon termination of marriage.

HEALTH BENEFIT IMPROVEMENTS

Implementation of Public Law 93–246 (enacted January 31, 1974): Effective the first pay period after January 1, 1975, the Government contribution toward the cost of health benefits is increased from 50 percent to 60 percent of the average cost of the six largest health plans, not to exceed 75 percent of any individual plan or option.

Also included in this law is a provision which authorized a one-time opportunity for retired employees and survivor annuitants enrolled, or eligible to enroll, under the Retired Federal Employees Health Benefits Program to change to an enrollment under the Federal Employees Health Benefits Program.

LIBERALIZED RETIREMENT OPPORTUNITY

Implementation of Public Law 93–350 (enacted July 12, 1974) retirement provision: This law, which amended the Civil Service Retirement law, grants liberalizations for retirement eligibility and computation of annuity to both law enforcement officers and firefighters.

COMMISSION PARTICIPATION IN WORK GROUPS ON AGING

The Commission has provided representatives to five work groups investigating problems of older Americans. As part of the Administration on Aging, Task Forces of the Interdepartmental Working Group on Aging have conducted studies of concerted actions the Federal Government may take concerning problems relating to older persons. The five Task Forces at which a Commission representative was active were Nutrition, Information and Referral, Research, Statistics, and Transportation.

ITEM 14. COMPTROLLER GENERAL OF THE UNITED STATES

FEBRUARY 20, 1975.

DEAR MR. CHAIRMAN: This is in response to your December 20, 1974, request for information on our major activities concerned in one way or another with aging. We are enclosing a listing of reports issued since July 1, 1973, on reviews of Federal programs which either directly or indirectly impact on the elderly population (Enclosure 1). We have also included a listing of reviews in process which concern the elderly (Enclosure 2). Copies of the issued reports are being provided to your office separately. Each report contains a summary of the major findings and conclusions in either a digest bound in the report or the letter transmitting it.

In addition, we are enclosing a statement on the General Accounting Office's "in-house" activities for the elderly (Enclosure 3).

Sincerely yours,

R. F. KELLER,
Deputy Comptroller General of the United States.

[Enclosures]

Enclosure 1.—*General Accounting Office Issued Reports Which Directly or Indirectly Impact on the Elderly Population*

Title	*Date*
Public Employment Programs in Selected Rural and Urban Areas	Aug. 1, 1973.
Additional Information on Certain Aspects of Independent and Hospital-Based Laboratories	Do.
Award of Subcontract for Processing Medicare Claims for Physicians' Services in Ohio and West Virginia	Aug. 2, 1973.
Study of the Application of Reasonable Charge Provisions for Paying Physicians' Fees Under Medicare	Dec. 20, 1973.
Review of the Extent to Which General Revenue Sharing Funds Are Being Allocated to Programs Designed to Benefit the Elderly	Feb. 14, 1974.
The Emergency Employment Act: Placing Participants in Nonsubsidized Jobs and Revising Hiring Requirements	Mar. 29, 1974.
Effectiveness of Project FIND—Helping the Elderly Obtain Food Assistance and Other Services	Apr. 5, 1974.
Award of a Contract and a Grant to the Federation of Experienced Americans, Inc., and Related Financial and Program Activities	May 13, 1974.
Review of the State Plan Approval Process	May 14, 1974.
Report on the Regional Operations of the Administration on Aging	Aug. 15, 1974.
Need to More Consistently Reimburse Health Facilities Under Medicare and Medicaid	Aug. 16, 1974.
Employment Opportunities in the Federal Government for the Physically Handicapped	Sept. 16, 1974.
Review of Direct Assistance Programs Administered by the Administration on Aging	Sept. 19, 1974.
Report on Preretirement Counseling Programs	Nov. 12, 1974.
Grants to Improve Bus Transit Systems—Progress and Problems	Nov. 25, 1974.
Further Improvements Needed in Processing Widows' Claims for Black Lung Benefits	Dec. 31, 1974.
National Rural Development Efforts and the Impact of Federal Programs on a 12-County Rural Area in South Dakota	Jan. 8, 1975.
Housing for the Elderly—Factors Which Should Be Evaluated Before Deciding on Low- or High-Rise Construction	Jan. 9, 1975.
Review of Certain Provisions of Title III of the Older Americans Act of 1965, as Amended	Feb. 4, 1975.
Local Housing Authorities Can Improve Their Operations and Reduce Dependence on Operating Subsidies	Feb. 11, 1975.

Enclosure 2.—*General Accounting Office Reviews in Process Which Concern the Elderly*

Review of Architectural Barriers and Their Elimination in Public Buildings.*
Study of Area Agencies on Aging.*
Review of the ACTION Program.

Enclosure 3.—*General Accounting Office's Internal Activities for the Elderly*

The General Accounting Office actively recruits qualified personnel, regardless of age. This is especially true in hiring for upper-level positions. During the first half of Fiscal Year 1975, we hired 76 employees, 17 of whom were over 40 and several were well into their fifties.

Our policy also provides that training not be restricted to the younger employee. This policy has resulted in many of our older employees, several of whom are of retirement age, receiving training to increase their effectiveness and opportunities for further advancement. Additionally, the Office recognizes the importance of dealing with the older employee and includes this topic in its "in-house" courses on supervision.

The Employees Health Maintenance Examination, a comprehensive and professional medical examination, has been available for several years at no charge to GAO employees who are 40 years and older and who are in grades GS-11 and above. A project currently under development will extend coverage of this benefit to all employees 40 years of age and older.

Individual preretirement counseling is available to all employees of the Office who are approaching retirement age. A daylong Preretirement Conference is held periodically, dealing with topics of annuities, life insurance, medicare and other health benefits, social security, etc. Announcements of the availability of the Conference, counseling, and other topics of special interest to the older employee are regularly published through memorandums and in the GAO Employees Association monthly newspaper, "The Watchdog" which is available to retirees at reduced rates.

The employees of GAO are aware of the Equal Employment Opportunity channels for filing complaints of alleged discrimination because of age provided by law and implementing Civil Service Commission regulations since July, 1974. Our Equal Employment Opportunity Office has been providing counseling in the area of age discrimination for approximately 18 months.

ITEM 15. CONSUMER PRODUCT SAFETY COMMISSION

MARCH 10, 1975.

DEAR MR. CHAIRMAN: This letter is in response to your request of December 20, 1974, for a statement regarding the Consumer Product Safety Commission's activities in 1974 for the aging, and our plans for continuing efforts in 1975. We apologize for the inordinate delay in responding.

None of the laws administered by the Consumer Product Safety Commission is solely applicable to the aging. However, older Americans are particularly vulnerable to a variety of risks of injury which may be associated with consumer products. Therefore, the Commission's efforts to prevent such risks and to educate the consumer are of value to the aging.

I hope the enclosed statement will be useful. Please let me know if I can be of any further assistance.

Sincerely,

RICHARD O. SIMPSON, *Chairman.*

[Enclosure]

PROGRAMS RELATING TO THE AGING

Each year an estimated 20 million Americans of all ages are injured by products used in and around the home: 110,000 are permanently disabled, and 30,000 are killed. Recognizing the need for Federal regulations to insure safer consumer products, the Congress, in 1972, passed the Consumer Product Safety

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*Being performed at the request of Congress.

Act, P.L. 92-573, which called for the creation of a Consumer Product Safety Commission. The Commission was charged with the mission of reducing the number and severity of product related consumer injuries, illnesses, and deaths. While none of the laws administered by the Consumer Product Safety Commission is solely applicable to the aged, older Americans are particularly vulnerable to risks of injury associated with consumer products, and do benefit from many of the Commission's activities.

INJURY DATA COLLECTION

At the present time, the Commission's primary source of information concerning product related injuries is the National Electronic Injury Surveillance System (NEISS). The NEISS is composed of a statistically selected set of 119 hospital emergency rooms located throughout the country which report product related injuries treated in the emergency rooms to the Commission on a daily basis. In 1974, 9,142 reported cases of injuries to the elderly (persons 65 years of age or older) were treated at NEISS hospitals.

The majority of these cases (87 percent) were treated and released; 12 percent were hospitalized; and 1 percent were treated at the NEISS emergency rooms and transferred to other hospitals for further treatment. Twelve persons were dead on arrival. Of the 9,142 injuries to the elderly reported through the NEISS system, injuries associated with stairs, ramps, and landings lead the list, with 979 cases. Based on the 9,142 cases reported through the NEISS during 1974, we have projected that 216,000 cases of injury to the elderly were treated in the nation's emergency rooms in 1974.

STANDARDS

Special studies are being conducted by the Commission, designed to address unsafe conditions according to the age of the injured, among other things. Besides injuries associated with ramps, landings, and stairs, other studies which consider the aging deal with bathroom hazards and hazards associated with doors.

One potential solution to product hazards is the development of mandatory standards. Where applicable in the development of product safety standards, consideration is given to the problems of the aging.

In addition to addressing hazards to the elderly, the Commission also considers the effects of safety standards. The Commission's Bureau of Engineering Sciences examines safety devices and procedures requiring manual dexterity on the part of users, with cognizance that these faculties may be reduced in some elderly persons. With respect to the economic impact of regulations, the Commission's Bureau of Economic Analysis identifies differential effects of Commission action on subsets of the population by age, income, and location.

In the notice requesting offers to develop a proposed standard for bookmatches, under the *Consumer Product Safety Act*, the Commission indicated that the hazards to adults, including the elderly, are to be considered as well as the hazards to children. Also, the standards development activity underway for architectural glass and gas space heaters will result ultimately in a safer product for use by all persons, including the aging.

The *Federal Hazardous Substances Act* requires cautionary labeling on those household substances which may cause substantial injury or illness. When no type of labeling would be sufficient to reduce the hazard, the Commission may, by rule, ban the substance.

The *Poison Prevention Packaging Act* requires that those substances packaged for household use which may cause serious personal injury or serious illness to children as a result of their handling, using or ingesting such substances must be packaged in special, child-resistant packaging. Congress recognized the problems aging and/or handicapped individuals may have with special packaging and provided, in Section 4 of the Act, that prescription drugs subject to the child-resistant packaging standards may be dispensed in conventional, noncomplying packaging if the prescribing physician or the purchaser specifically requests such packaging. In addition, nonprescription drugs and other household products subject to special child protection packaging standards may be marketed in a single size, conventional noncomplying package if the product is also supplied in complying packaging, and if the noncomplying package bears the label statement: "This package for households without young children."

In addition, the child-resistant packaging requirement for oral prescription drugs specifically excludes sublingual dosage forms of nitroglycerin, in consideration of those individuals with heart conditions, many of whom are elderly.

The *Flammable Fabrics Act*, as amended, authorizes the Commission to promulgate flammability standards for wearing apparel, fabric and interior furnishings which present an unreasonable risk of death, injury or property damage. Under this Act, standards which affect the elderly have been established for carpets and rugs, and mattresses. In addition, the Consumer Product Safety Commission is currently developing a proposed flammability standard for upholstered furniture. (The elderly and handicapped frequently are victims of upholstered furniture fires by falling asleep and dropping lit cigarettes on the furniture. Their injuries are often more serious because generally they cannot react quickly enough to save themselves by the time they become aware of the fire.) The Commission also is investigating the possibility of broadening flammability standards to include such items as housecoats, robes, nightgowns, pajamas, dresses, shirts, and trousers.

Studies are being conducted to develop new test methods which will predict more accurately the flammability hazards associated with all wearing apparel and interior furnishings. Future standards should provide considerable protection from burn injuries associated with textile material to the elderly, as well as to the public in general.

INFORMATION AND EDUCATION

The Commission's Bureau of Information and Education is also involved in programs relating to the elderly. The Bureau is currently developing studies to determine the awareness and attitudes toward product safety of all age groups, including those over 65. In addition, a variety of educational materials have been prepared and widely distributed, including fact sheets on "The Elderly and Stairway Accidents," "Upholstered Furniture," "Stairs, Ramps, Handrails and Landings," "Bathtub and Shower Injuries," "Kitchen Ranges," and "Flammable Fabrics."

Recognizing that many elderly persons may not be aware of the special packaging exemption under the Poison Prevention Packaging Act, the Commission currently is preparing an information campaign, targeted at the elderly and the handicapped, to explain the exemption. This will mark the first attempt of the Commission to reach specifically the elderly and the handicapped on a nationwide basis.

ITEM 16. ENERGY RESEARCH AND DEVELOPMENT ADMINISTRATION

JANUARY 30, 1975.

DEAR SENATOR CHURCH: I am pleased to submit the enclosed report in response to your letter of December 20, 1974, requesting information for inclusion in the forthcoming annual report of the Senate Special Committee on Aging.

The Energy Research and Development Administration, formerly the Atomic Energy Commission, has for many years sponsored large-scale research efforts aimed at evaluating the health risk associated with latent somatic damage produced by radiation in humans and experimental animal populations. These studies are necessary to produce a rational cost/risk/benefit analysis of nuclear energy technology as part of the national program of energy development. The mission of this Agency has been expanded to encompass similar assessment for a variety of alternative energy-producing technologies. These research activities now come under the responsibility of the Energy Research and Development Administration. The comparative type of information that will be derived from an expanded effort should be most valuable for an overall assessment of environmental impact on human health and the diseases that limit the human lifespan.

As the enclosed report indicates, we have chosen, as we did last year, to identify research *directly* related to aging in human and animal populations, which received only a minor increase in funding during fiscal year 1974 and thus remains at approximately $4 million, and research *indirectly* related to aging, which includes detailed evaluation of latent diseases contributing to morbidity or mortality in unstressed populations in comparison to environmentally stressed populations which show premature morbidity or mortality. The latter research efforts were increased to approximately $14 million during fiscal year 1974.

I hope the information provided in the enclosed report will be helpful and that you will call on me if further assistance is required.

Sincerely,

JAMES L. LIVERMAN,
Director, Division of Biomedical and Environmental Research.

[Enclosure]

PROGRAM OF RESEARCH ON AGING SPONSORED BY THE ENERGY RESEARCH AND DEVELOPMENT ADMINISTRATION

The Energy Research and Development Administration, formerly the Atomic Energy Commission, has for more than 25 years sponsored a broad-based biological research program to evaluate the health and environmental impact of the nuclear energy technology. During Fiscal Year 1974 the mission of this Agency was broadened to encompass the appraisal of long-term health and environmental risks associated with other energy-related pollutants, namely, chemical agents associated with nuclear energy production as well as energy production by alternative energy sources. Emphasis is placed on those toxic agents to which man is exposed at every stage of the fuel cycle from mining the ore to final utilization of the energy resource.

It is essential in such research to stress the latent somatic, genetic, teratogenic and patho-physiological effects in man, as well as model experimental animals, that may result from continuous low-level exposure. In order to facilitate the extrapolation of experimental results to man, it is necessary to use short- and long-lived animal species and to understand age-related differences in production of these latent effects. Thus, most of the research permits an evaluation of the disease states that occur throughout the entire lifespan in normal animal populations and under the stress of exposure to radioactive and/or non-radioactive environmental pollutants. Every effort is made to identify the cause of death in stressed and unstressed animal populations, and a large amount of supporting research is conducted to facilitate understanding the sequence of events and mechanisms involved in production of fatal diseases at the whole animal, tissue, cellular and molecular levels of organization. The latter studies contribute also to the information needed to develop any realistic methodology to prevent or reduce the degenerative processes that contribute to normal senescence or specific malignancies that bring about reduction of lifespan.

Most of these research efforts complement the types of biomedical research sponsored by the National Institute of Child Health and Human Development which will be coordinated under the newly established National Institute of Aging.

LONG-TERM HUMAN STUDIES

Since the late-effects research program is aimed at prediction of damage to the human population, long-term followup of four major human populations with radiation exposure histories is being continued. As the responsibilities of this Agency increase in terms of other energy-related pollutants, new human epidemiological studies may be initiated. At present, human population studies are of major interest to all agencies concerned with human health.

A new joint American-Japanese Radiation Effects Research Foundation has been created to replace the ABCC and continue lifetime followup of the 100,000 Japanese nationals exposed to radiation at Hiroshima and Nagasaki. Detailed and routine clinical observations, including disease states that contribute to morbidity and mortality, will be made on both exposed and control groups on a continuing basis. To date no significant radiation-induced life shortening other than that due to malignant diseases has been noted.

A small group of 200 humans from the Marshall Islands, who were exposed accidentally to fallout from a thermonuclear weapon test, have been followed for the past 20 years by a group of medical investigators at Brookhaven National Laboratory. The Marshallese were exposed to substantial quantities of radioiodine and have therefore developed a number of thyroid abnormalities, which have been corrected by therapy or surgery. As in the case of the Japanese population, these people have shown no symptoms of premature aging.

Two human occupational groups who have received radiation exposure are being followed in some detail. A small group which has accumulated high body burdens of radium is being systematically followed by investigators at the Center for Human Radiobiology, Argonne National Laboratory. The exposed individuals have high levels of radium in their skeletons and thus are continuously exposed over their entire lifespan. Since the chief exposure is specifically to bone, the information derived from this study may well be valuable to understanding some of the specific degenerative processes associated with senescence. A large retrospective epidemiological study of 170,000 employees of the AEC production and laboratory facilities is being conducted by the management contractors of the AEC facilities, a group of epidemiologists at the University of Pittsburgh, and the Social Security Administration. The study population comprises individuals who spent part of their lives in the nuclear energy program. Thus, some were exposed to low doses of radiation, while others received none. Many of the ordinarily encountered environmental variables, such as geographical distribution, will be controlled in these studies. Health records, including morbidity and mortality information, will be available on this large group of individuals.

LIFETIME STUDIES ON LONG-LIVED MAMMALS

Although the aforementioned human studies are valuable for supplying direct estimates of adverse effects of radiation on man, they are inadequate to provide the detailed, quantitative data necessary for the estimation of health risks that form the basis for exposure guidelines and standards. Information of this type will have to be derived from comparative studies on long- and short-lived species. The beagle dog, whose life expectancy is about 1/5 that of man, has been the major long-lived mammal utilized in the ERDA radiation effects research for more than 20 years. At the University of Utah, the University of California at Davis, the Pacific Northwest Laboratory, Argonne National Laboratory and the Inhalation Toxicology Research Institute more than 5,000 beagles have lived out their lifetime under careful experimental observation. Periodic clinical examination has revealed a wealth of information about the pattern of diseases throughout the lifespan of normal animals and alterations in the pattern caused by superimposed stress of radiation exposure. Every effort should be made to capitalize on the geriatric information evolving from this animal resource. Only minor efforts have been made to date in this regard.

LONG-TERM RESEARCH WITH OTHER SPECIES

Small rodents with lifespans of two to six years have been used primarily for large-scale radiation studies to evaluate late somatic and genetic risks involved in low-dose lifetime exposure. Moreover, small laboratory and wild rodent populations have been used at Argonne National Laboratory to specifically understand the genetic and physiological factors involved in aging *per se*. At Argonne National Laboratory and Holifield National Laboratory, formerly the Oak Ridge National Laboratory, combined, more than 50,000 mice have been exposed to various doses of ionizing radiation at various daily exposure rates to characterize the various disease states that contribute to lifespan reduction. The unexposed, control populations are characterized, as well as the irradiated groups, in terms of the diseases that cause death.

It is anticipated that similar studies will be conducted to evaluate the late somatic effects produced by other potentially hazardous chemical pollutants introduced into man's environment from a variety of energy-producing technologies. Since man is constantly exposed to a number of such environmental pollutants, it is suspected that they contribute to reduction of his lifespan. Although radiation does not seem to contribute to non-specific lifespan reduction, it is likely that other environmental pollutants do. The anticipated studies should produce a large pool of information for understanding the development of latent somatic damage which contributes to morbidity and mortality under conditions of environmental stress.

RESEARCH SPECIFICALLY CONCERNED WITH AGING

Two programs, one at Argonne National Laboratory and one at Holifield National Laboratory, funded by the ERDA at about one million dollars, are concerned with the theoretical, genetic and physiological aspects of aging, including changes in the microvasculature. The program at Holifield is aimed at gaining an understanding of how normal body defense mechanisms, primarily immune surveillance against disease, are reduced in aging mice and hence make the old individual more prone to certain diseases that can incapacitate or kill. A part of the research is aimed at developing immune therapy to counteract reductions in body defense mechanisms by cell transplantation. This latter study is done in collaboration with investigators at the Gerontology Research Center in Baltimore. Since immune surveillance may play an important role in prevention of malignant diseases, including those induced by environmental agents, these studies are of interest to a number of agencies concerned with human health. At Argonne National Laboratory research has emphasized homeostatic control, localized in the brain, as a regulator of aging or lifespan. In this regard, studies at Brookhaven National Laboratory suggest that certain monoamines, fed to rodents, can increase their lifespan.

Parts of several research efforts at Holifield National Laboratory, the University of California at San Francisco, and Brookhaven National Laboratory involve studies to test the cellular hypothesis of aging using either *in vivo* or *in vitro* cell systems.

In addition to these studies, the ERDA has always sponsored small efforts in aging research in various university departments.

CLINICAL ASPECTS OF AGE-RELATED DISEASES

In addition to the aforementioned research areas, the ERDA Biomedical Program contributes more than 10 million dollars per year in research and development aimed at developing improved methods for the early diagnosis and treatment of diseases that contribute to morbidity or mortality of human populations, including the aging or aged. For example, at Brookhaven National Laboratory a segment of the nuclear medicine program involves clinical and experimental research on hypertension and senile osteoporosis as well as Parkinson's Disease.

SUMMARY

Although the ERDA has no specific mission in geriatric research, it is clear that the ongoing and planned research program contributes in a real way to understanding the relationships of disease states to reduction of lifespan. Information is generated at the theoretical, molecular, and cellular level, as well as the whole animal and human level, which will be valuable to understanding of this facet of the aging process in man.

ITEM 17. FEDERAL COUNCIL ON THE AGING

JANUARY 31, 1975.

DEAR SENATOR CHURCH: The Federal Council on the Aging herewith submits its report to you, for inclusion in your annual report to the Senate of Federal Units concerned with aging.

I speak for the Council in expressing appreciation for your continuing interest in the problems of the nation's elderly.

Sincerely,

BERTHA S. ADKINS, *Chairman*.

[Enclosures]

CALENDAR YEAR REPORT FOR 1974

The Federal Council on the Aging was created by the Congress under provisions of the 1973 amendments to the Older Americans Act, for the purpose of advising the President, the Secretary of the Department of Health, Education, and Welfare, the Commissioner on Aging and the Congress on matters relating to the special needs of older Americans. Its establishment was an effort to respond to a broader range of problems affecting the elderly than had been possible within the scope of the predecessor body, the Advisory Committee on Older Americans.

The Older Americans Act directs the Federal Council on the Aging to perform the following functions:

(1) Advise and assist the President on matters relating to the special needs of older Americans;

(2) Assist the Commissioner in making the appraisal of the Nation's existing and future personnel needs in the field of aging;

(3) Review and evaluate the impact of Federal policies regarding the aging and programs and other activities affecting the aging conducted or assisted by all Federal departments and agencies for the purpose of appraising their value and their impact on the lives of older Americans;

(4) Serve as a spokesman on behalf of older Americans by making recommendations to the President, to the Secretary, the Commissioner, and to the Congress with respect to Federal policies regarding the aging and federally conducted or assisted programs and other activities relating to or affecting them;

(5) Inform the public about the problems and needs of the aging, in consultation with the National Information and Resource Clearinghouse for the Aging, by collecting and disseminating information, conducting or commissioning studies and publishing the results thereof, and by issuing publications and reports;

(6) Provide public forums for discussing and publicizing the problems and needs of the aging and obtaining information relating thereto by conducting public hearings, and by conducting or sponsoring conferences, workshops, and other such meetings.

MEMBERSHIP

The Council officially got underway with the approval by the Senate on June 5, 1974 of the fourteen persons nominated by the President on March 27, 1974. A fifteenth member has been added to the group to complete the number called for by Section 205 of Public Law 93-29. The Secretary of the Department of Health, Education, and Welfare and the Commissioner on Aging serve as ex-officio members of the Council.

Nine members of the Council are themselves older persons. They and the other members fully represent older Americans, national organizations with an interest in aging, business, labor, and the general public as called for in the law. The Council roster is attached to this report.

COUNCIL SUPPORT

According to provisions of the Older Americans Act, the Secretary of the Department of Health, Education, and Welfare and the Commissioner on Aging are to make available to the Council such staff, information, and other assistance as it may require to carry out its activities. This is done in a variety of ways.

The Secretariat for the Federal Council on the Aging is located in the Administration on Aging. Initial staff was provided by transfer of the Staff Director and her secretary from the Advisory Committee on Older Americans. Two professional staff persons and a secretary have since been added. One more professional slot has been requested within fiscal 1975. Additional positions have been requested for FY 1976 when the Council expects to be operating at its full pace.

The placement of the Secretariat in AoA and the Office of Human Development provides informal as well as formal utilization of their staffs and supportive services. The Committee Management office in the Office of the Secretary aids in carrying out the provisions of the Federal Advisory Committee Act. Various units within departments other than HEW have given prompt response to FCA requests for resource speakers and materials.

Contractual and other short-term employees have been utilized to assist with certain FCA projects such as the Congressionally-mandated studies. The FCA budget for FY 1975 of $500,000 is provided as part of the AoA appropriation. The President's FY 1976 budget proposes the same level of funding as the previous year, but creates a separate line item for the FCA.

COUNCIL MANAGEMENT

Three meetings of the full Council and two meetings of the three committees which have been formed were held in 1974. Establishing these three sub-units of the Council was an effort to categorize and facilitate work on the sizable assignment given by the Congress. The Committee on Senior Services is headed by John Martin, former Commissioner on Aging. Nelson Cruikshank, President of the National Council of Senior Citizens and member of several advisory councils to the Social Security Administration chairs the Committee on the Economics of Aging. A past President of the Gerontological Society and head of the Department of Psychiatry at the University of Washington, Carl Eisdorfer, chairs the Committee on Research and Manpower in the field of aging. These Committee groupings are not seen as permanent and will be rearranged from time to time to fit FCA priorities.

In addition to operational conditions and requirements set by its own legislation, the FCA is governed by the Federal Advisory Committee Act. Complying with this law and its regulations as set forth by HEW and the Office of Management and Budget, the following actions have been taken and procedures established:

—All Council and Committee meetings are open to the public with advance notice in the Federal Register. Fifteen to twenty-five persons usually attend Council meetings as observers.

—About 150 notices of each Council meeting are being sent to national organizations in the field of aging, Federal and State government officials, members of the Congress and their staffs and individual citizens.

—Minutes of the Council and Committee meetings are distributed to the public upon request.

—Minutes and all other documents relevant to Council official actions are maintained in the office of the FCA Secretariat and are available for public inspection and copying. Copies are available under provisions of the Freedom of Information Act.

—Reports on Council activity appear regularly in AGING magazine and press releases are prepared on all major Council actions.

COUNCIL ORIENTATION

As a new entity concerned with developing priorities out of the broad mandate given by the Congress, the Federal Council devoted a considerable amount of time at both Council and Committee meetings in 1974 in learning about various Federal programs from the officials involved. They heard from the Commissioner on Aging as well as representatives of various units within the Administration on Aging, the Office of Research and Statistics of the Social Security Administration, the Assistant Secretary for Human Development, staff of the Senate Special Committee on Aging, HEW Office of Nursing Home Affairs and the National Institute of Health.

A wide variety of materials was assembled and distributed to Council members as part of a general orientation to their mission.

CONGRESSIONAL STUDIES

As described earlier in this report, the Congress directed that the Council should undertake three specific studies.

A study on State formulae for funding programs under the Older Americans Act was carried out by an outside contractor under the supervision of the FCA Committee on Senior Services. At the December meeting of the Council, recommendations proposing changes in the State formulae based on the study were proposed by the Committee and adopted by the Council at its December 5-6 meeting. As called for in the Act, a report containing the recommendations of the Council and relevant parts of the study was submitted on December 30, 1974 to the Commissioner on Aging, the Secretary of Health, Education, and Welfare, the Committee on Labor and Public Welfare of the Senate, and the Committee on Education and Labor of the House of Representatives.

At the request of the Commissioner on Aging, the scope of the Formulae study had been expanded beyond the effects of the formulae specified in Section 303 to include the funding of planning, coordination, evaluation and administration of State plans in Section 306 and the funding of nutrition programs in Section 703. The major FCA recommendation was that the factor of "the population aged 60 or over who are living in poor households" should be added to the factor of the number of State residents aged 60 or over in all the present State allotment formulae in the Older Americans Act. Several recommendations were also made concerning increases and modifications in State administrative funding.

Work is underway on the two other studies mandated by the Congress. These were to have been completed by January 1, 1975 but, with the delay in processing

FCA membership, postponement for one year has been requested in S. 599 introduced in the Senate February 7, 1975.

The study on the interrelationships of benefit programs for the elderly operated by Federal, State and local government agencies will be carried out by outside contractors. The work statement has been developed by FCA staff, in concert with FCA members, out of contacts with a wide range of experts in the Department of Health, Education, and Welfare. There has also been several consultations with the staff of the Subcommittee on Fiscal Policy of the Joint Economic Committee of the Congress.

The study of the combined impact of all taxes on the elderly has been assigned to the FCAs Committee on the Economics of Aging. There has been consultation with governmental and nongovernmental sources on obtaining basic data on tax expenditures of the elderly. The Census Bureau has been developing material for the Treasury Department which seems to be the most pertinent. The availability of these data is determining the pace of FCA actions on this Congressional mandate.

POLICY POSITIONS

Since confirmation of its members by the Senate in June 1974, the Council has attempted to carry out the goals set for it by Congress, namely, to speak out for the older citizens of this nation at the Federal level.

Positions have been taken on a number of matters and communicated to the President, the Congress, the Secretary of Health, Education, and Welfare, other Federal officials and the general public. As a result of the September 10, 11, meeting, recommendations were made to the President and to the Secretary of Health, Education, and Welfare, and the Commissioner on Aging concerning:

Setting the Intermediate Budget level of the Bureau of Labor Statistics for older retired persons as the standard for national income policy for older Americans, (in autumn of 1973 this figure was $5414 U.S. average for retired urban couples).

Giving appropriate attention to the employment of persons 55 years of age or older in implementing the Comprehensive Employment Act with regulations providing for projects for the elderly;

Funding of senior employment programs under Title IX of the Older Americans Act;

Maintaining the level of funding for Senior Opportunities and Services in order to meet the needs of the elderly for social services, in any pending legislation affecting OEO programs;

Urging the continuation of the back-up function providing research support for legal services programs for the elderly as part of the mission of the Legal Services Corporation;

Provide legal services for the elderly in all community programs conducted under the auspices of the Legal Services Corporation;

Nominate to the board of the Legal Services Corporation persons fully representing the multi-faceted legal services needs of the elderly.

Following the December 5–6 meeting, the Council expressed to the President and to the Congress their deep concern about the financial burden that would fall on the elderly as a result of proposed fiscal year 1975 budgets cuts, in particular, the additional costs that would have to be borne by the aged in relation to Medicare, Medicaid and food stamps.

Roy Ash, Director of the Office of Management and Budget, responded for the President, acknowledging awareness of the Council's concern. Mr. Ash stated that benefits for those in need, including the elderly, would rise substantially over fiscal year 1974 in fiscal 1975.

Strong opposition to the Holt-Helms amendments to Labor-HEW appropriations Bill was expressed to Congress by the Council, terming the amendments an impediment to improving the status of older women and minority group members.

The Council also took action at its December meeting, in letters to the President, the Secretary of Health, Education, and Welfare and other Administration officials, endorsing the concept of a World Assembly on Aging, possibly in conjunction with a World Year on the Aging under the auspices of the United Nations. Favorable reaction was received from the White House, the Department of State and DHEW, to exploring the feasibility of such action.

HEARINGS

As directed by the Older Americans Act provisions regarding the Federal Council, two hearings were conducted during 1974 to "provide public forums for discussing and publicizing the problems and needs of the aging." A hearing conducted by the Council's Committee on Aging Research and Manpower was held on October 31st in Portland, Oregon. The date and location were chosen to coincide with the combined annual meeting of the Gerontological Society and the American Geriatrics Society. Leading gerontologists were asked to provide their assessments of research activities in the field of aging to give guidance to the Federal Council on the Aging in their monitoring responsibilities relative to Federal research programs.

The second hearing was conducted by the Committee on Senior Services as part of the development of the recommendations regarding revisions to State formulae for funding programs of the Older Americans Act. Only a few State agencies on aging were able to send representatives to Washington but many more provided valuable written comments which were included in the final report of the Council.

CHAIRMAN'S ACTIVITIES

As part of the general responsibility of the Federal Council on the Aging to make the public more aware of the needs and contributions of older Americans, the Chairman participated in a number of activities. Her major engagements included:

Moderator of ten television programs produced by the Administration on Aging for the NBC "Knowledge" series;

Rapporteur for the section on the Elderly at the HEW-Congressional Conference on Inflation on Health, Education, and Income Security and Social Services;

Speaker at the Massachusetts Department of Elder Affairs national conference entitled "Old Age—A New Look."

COUNCIL AGENDA—1975

Developing priorities for the Federal Council on the Aging, aside from the specific assignments given by Congress, has been a difficult task. There are so many matters affecting the elderly that demand attention at the national level. The Federal Council does not want to be a passive advisory body but neither does it want to be a chatterbox for superficial criticisms and proposals nor just an endorser of what others say about older Americans.

While there will be continued work on short-range and mid-range problems and observations on the implementation of Federal laws and programs, it was determined at the December meeting to focus on two long-range matters affecting the elderly that are not yet receiving the prominence of national policy debate which they deserve.

The target group has been narrowed to persons usually but not always over the age of 75 who require one or several supportive services in order to cope with daily life. They are expected to become a sizable percentage of this country's population well before the end of this century. Today, they are referred to in such problem areas as "nursing home reform", "alternatives to institutionalization", "community care", "home care" and "isolation".

The Council hopes to focus national attention on the policy issues inherent in the needs of this vulnerable population with their long-term and costly requirements for support services.

At the next regular meeting of the Council in March, a group of experts will be invited to attend to help in further defining the issue and in determining the unique and specific actions the Federal Council might carry on to stimulate attention to this major national dilemma.

At the next regular meeting of the Council in March, a group of experts will share their thinking on the second priority of the FCA. It is important that an income assurance system for this nation's elderly be developed which successfully integrates Supplemental Security Income, Social Security payments, private pensions with appropriate Federal safeguards and other private income sources. The Council wants all older persons to have a solid income flow but it is imperative that financial security be assured to the most vulnerable and fragile of the nation's elders.

MEMBERS OF THE COUNCIL

Chairman: Bertha S. Adkins.

Executive Director: Cleonice Tavani, Federal Council on the Aging, Room 4022, Donohoe Building, 400 6th Street, SW., Washington, D.C. 20201

For a Term of 1 Year (to 6–5–75)

Bertha S. Adkins, of Oxford, Maryland, former Under Secretary of the Department of Health, Education, and Welfare.

Dorothy Louise Devereux, of Honolulu, Hawaii, former Member of the Hawaii State House of Representatives.

Carl Eisdorfer, M.D., Ph. D., of Seattle, Washington, Professor and Chairman, Department of Psychiatry and Behavioral Sciences, University of Washington, past President of the Gerontological Society.

Charles J. Fahey, The Reverend Monsignor, of Syracuse, New York, Director of the Catholic Charities for the Roman Catholic Diocese of Syracuse and President elect of the American Association of Homes for the Aging.

John B. Martin, of Chevy Chase, Maryland, former Commissioner on Aging, Special Consultant to the American Association of Retired Persons and the National Retired Teachers Association.

For a Term of 2 Years (to 6–5–76)

Frank B. Henderson, of Worthington, Pennsylvania, Director, Nutrition Services, Armstrong County Community Action Agency.

Frell M. Owl, of Cherokee, North Carolina, Retired from the Bureau of Indian Affairs; Member of the Indian Advisory Council of the United States Senate Special Committee on Aging.

Lennie-Marie P. Tolliver, of Oklahoma City, Oklahoma, Professor and Associate Director, School of Social Work, the University of Oklahoma.

Charles J. Turrisi, of Norfolk, Virginia, retired as General Superintendent of Mails of Norfolk. He is legislative chairman for the Norfolk Chapters of the National Association of Retired Federal Employees and the American Association of Retired Persons.

Selden G. Hill, of Orlando, Florida, is a member of the Advisory Board of the Florida State Division on Aging. He was Assistant Director of the War Manpower Commission of the U.S. Civil Service Commission.

For a Term of 3 Years (to 6–5–77)

Nelson Hale Cruikshank, of the District of Columbia, President, National Council of Senior Citizens. Former Director of Department of Social Security, AFL–CIO.

Sharon Masaye Fujii, of Santa Monica, California, Vice President of Gerontological Planning Associates.

Hobart C. Jackson, of Philadelphia, Pennsylvania, Executive Vice President, Stephen Smith Geriatric Center and Administrator of the Stephen Smith Home for the Aged. Mr. Jackson was the founder of the Caucus of the Black Aged and presently serves as Chairman.

Garson Meyer, of Rochester, New York, former Chief Chemist, Eastman Kodak and the President Emeritus of the National Council on the Aging.

Bernard E. Nash, of Camp Springs, Maryland, Executive Director of the National Retired Teachers Association and the American Association of Retired Persons.

Ex-Officio Members

The Secretary of Health, Education, and Welfare.
The Commissioner on Aging.

ITEM 18. FEDERAL ENERGY ADMINISTRATION

March 5, 1975.

Dear Mr. Chairman: During 1974, the Federal Energy Administration has taken several steps to address the energy related problems of the aged. The following is a list of actions directed specifically at the aging:

1. The Office of Consumer Affairs/Special Impact of FEA in conjunction with the Administration on Aging and ACTION conducted a survey to examine the effects of increased gasoline costs on volunteers who offer driving services for aging programs. The results of that study were discussed before the Senate Special Committee on Aging on September 25, 1974.

2. The Director of the Office of Consumer Affairs/Special Impact has been selected to represent FEA on a sub-cabinet level Task Force on Aging, which is chaired by Commissioner Flemming of the Administration on Aging. Through work with the Task Force, FEA has outlined to other Federal agencies the energy related problems of the aged.

3. FEA has entered into two interdepartmental working agreements with the Administration on Aging and several other Federal agencies. The working agreements address energy conservation actions for the aged as well as information and referral services for the aged. The following actions are being taken by FEA to implement these working agreements:

—FEA will direct the attention of the State Offices of Petroleum Allocation to the interdepartmental working agreements and recommend that they make available, on an ongoing basis, information about fuel allocation and energy policies to State and Area Agencies on Aging.

—FEA will send letters to State and local energy task forces encouraging them to assign representatives from consumer and older persons' organizations to the task forces.

—FEA will assist all Regional, State and Area Agencies on Aging by providing technical advice, educational and training material which includes model programs for the training of persons involved in the winterization of buildings that are owned and occupied by the low income elderly.

—FEA will also provide regional orientation sessions on fuel allocation and energy policies to the Regional, State and Area Agencies on Aging.

4. FEA has developed legislation for the President which proposes to provide subsidies for insulation and other thermal home improvements to the homes of the poor and elderly.

5. Presently, the Office of Consumer Affairs/Special Impact of FEA is conducting a study of the impact of rising energy costs upon the aged through a contract with Applied Management Sciences, Inc. of Silver Spring, Maryland. A preliminary report of the study was completed on February 10, 1975, and has been submitted to you for review and comment before the final version of the report is published. This study will be used over the next year as a basis for determining policy options and recommendations concerning the energy related problems of the aging.

I hope that these comments will assist you in drafting the Annual Report for the Senate Special Committee on Aging.

Sincerely,

FRANK G. ZARB, *Administrator.*

ITEM 19. FEDERAL TRADE COMMISSION

FEBRUARY 21, 1975.

DEAR SENATOR CHURCH: This letter is in response to your request of December 20, 1974, for a report summarizing the Federal Trade Commission's major activities on aging during 1974 and providing you with information as to our plans for 1975. Although none of our laws are specifically directed to the aged, as a matter of policy, both the staff and the Commission regard that segment of the population as particularly vulnerable to fraud and deception and are increasingly aware of often pressing economic plight of such Americans. We are therefore concerned with developing programs with that in mind so that to the extent possible, we can contribute to improving the quality of life of such older Americans. The following programs are of that sort.

1. *The Proposed Trade Regulation Rule on Food Advertising.* The purposes of the proposed rule are to increase the ability of consumers, including the elderly, to make more informed choices between foods for nutritional reasons, and also to compare nutritional values to costs.

2. *The Hearing Aid Cases and Investigation Regarding Possible Proposed Trade Regulation Rule on Hearing Aid Sales Practices.* Six complaints were issued against the nation's largest hearing aid manufacturers, charging that their advertising practices are deceptive and unfair. The staff of the Bureau of

Consumer Protection is also conducting an investigation regarding a possible proposed Trade Regulation Rule for the Hearing Aid industry. It should be noted that the Commission has not had an opportunity to consider any proposal. Should the proposal be approved by the Commission, of course, a comment period would be provided and subsequently, hearings would be held to allow the fullest expression of views by those affected by the proposed rule.

3. *Denture Product Advertising.* Pursuant to the advertising substantiation program, two major companies were required to submit substantiation concerning advertising claims for denture cleaning products and a denture adhesive.

The Food Nutrition program will continue in 1975. The proceedings, including extensive hearings and analysis of the full record of those proceedings for the proposed Food Rule, will require a substantial commitment of resources.

The Hearing Aid Rule, if proposed, will also be in process during 1975.

I hope this information will prove helpful. Please call upon me or the staff if you need further information or further details.

Sincerely,

J. THOMAS ROSCH, *Director.*

ITEM 20. NATIONAL ADVISORY COUNCIL ON ADULT EDUCATION

FEBRUARY 10, 1975.

DEAR SENATOR CHURCH: The National Advisory Council on Adult Education welcomes the opportunity to provide adult education information for your Senatorial Special Committee on Aging. As a Council, we have reviewed and utilized the committee report (93-846) in our building of legislative specifications and providing advice to program planners at the federal, state, and local levels.

As you are aware from your exposure to public school adult education programs and community school thrusts in Idaho, the local school districts in concert with other community agencies have assumed a great deal of responsibility in providing learning enrichment activities for older citizens. The Federal Adult Education Act (P.L. 91-230) with its new amendments (P.L. 93-380) gives impetus to education programs which are applicable in addressing some problems of the aged and aging. We draw attention to provisions of the Federal Adult Education Act in these specific sections:

SEC. 302. STATEMENT OF PURPOSE

It is the purpose of this title to expand educational opportunity and encourage the establishment of programs of adult public education that will enable all adults to continue their education to at least the level of completion of secondary school and make available the means to secure training that will enable them to become more employable, productive, and responsible citizens.

SEC. 303. DEFINITIONS

(a) The term "adult" means any individual who has attained the age of sixteen.

(b) The term "adult education" means services or instruction below the college level (as determined by the Commissioner), for adults who—

(1) do not have a certificate of graduation from a school providing secondary education and who have not achieved an equivalent level of education, and

(2) are not currently required to be enrolled in schools.

(c) The term "adult basic education" means adult education for adults whose inability to speak, read, or write the English language constitutes a substantial impairment of their ability to get or retain employment commensurate with their real ability, which is designed to help eliminate such inability and raise the level of education of such individuals with a view to making them less likely to become dependent on others, to improving their ability to benefit from occupational training and otherwise increasing their opportunities for more productive and profitable employment, and to making them better able to meet their adult responsibilities.

(e) The term "community school program" is a program in which a public building, including but not limited to a public elementary or secondary school or a community or junior college, is used as a community center operated in conjunction with other groups in the community, community organizations, and local governmental agencies, to provide educational, recreational, cultural, and other related community services for the community that center serves in accordance with the needs, interests, and concerns of that community.

You will note in further reviewing the Adult Education Act that state plan provisions allow the distribution of funds to local education units on a cost sharing basis, 90/10, and that local units can establish or expand adult education programs. This permits preretirement programs, senior citizen enrichment and leisure time activities, or career renewal thrusts that would accomplish the purposes of the Act.

There is also provision in the law and the state plan program for Special Experimental Demonstration projects (Section 309) which could be directed to the interests of senior citizens.

Section 310 of the Federal Adult Education Act (Special Projects for the Elderly) which authorizes the U.S. Commissioner of Education to make grants providing educational programs for elderly persons whose ability to speak and read the English language has not been funded.

Just last week, the National Advisory Council on Adult Education released *A Target Population in Adult Education* which will constitute the core of the Council's Annual Report to the President. The President will forward the Annual Report to Congress in March.

In light of the time frames for your committee report, the Council is pleased to forward you a copy of this report. We recommend its review by the staff of the Special Committee on Aging, and the use of the many sections of the report that apply to older Americans.

The target population of adult education is a very diverse group, cutting across all sectors of the American society. However, the problems of some specific groups warrant special attention. One group is the older part of the population with below-the-norm school attainment.

Since the younger part of the population is the one caught up in the more recent advances in school attainment, it is not surprising to find that a very disproportionate part of the older age groups are the ones with lower levels of schooling.

More than one out of every four persons found to have less than 12 years of school and not enrolled in school in 1970 were 65 years of age and over; the adjacent age group 45 to 64 years of age accounted for another 38 percent of the total. Moreover, for both of these age groups, the concentration of people with very low levels of school attainment, e.g., no more than an elementary school education, was particularly heavy.

Some suggest minimizing resources for these persons because many of them will be leaving the work force through death and retirement. Here are three major countervailing points.

> The first is the fact that there is indeed mounting evidence of earlier retirement, particularly among men. This has been a factor in bringing about a major reversal in trend in recent years, i.e., a decline in the length of working life among men. Adult education can enrich and often make useful to society the retirement years.
>
> The second is a phenomenon more related to work. There is a very substantial number of persons in this country who do much needed volunteer work, especially in the fields of health, education, and social welfare. Some years ago, in fact, they performed the equivalent work of 900,000 full time, paid labor force members. Volunteer work prevails most among those with higher levels of schooling. Adult education can help people in these age groups direct their energies to such volunteer work.
>
> The third is even more work related. We note the connection between schooling and labor force participation. Nowhere is this connection more vivid than among older citizens. Among men 55–64 years of age, only about 70 out of every 100 with no more than eight years of school are still in the labor force as against 85 out of 100 for those who have finished high school. For the former group, the decline in worker rates during the past decade amounted to 13 percent, for the latter (with 12 years of school) it was less than half of that. Schooling does make a big difference. Adult education can make the critical difference permitting the older person to have the option of continued economic activity.

Therefore, the Council urges that special attention be paid to the older person in adult education programs.

Other sections of the enclosed report provide client information and demographic traits associated with elderly persons. These sections should be reviewed and pertinent information abstracted.

Certainly, the Federal Adult Education Act and other federal program thrusts, i.e., higher education community service, Older Americans Act, CETA, manpower programs, etc., are not the only educational programs which may provide learning opportunities for senior citizens.

It has been recently noted by the Commission on Non Traditional Study that 32 million Americans undertook some form of adult education this past year. Public schools, community junior colleges, institutions of higher education, labor, and business and industry provide programs which have senior citizen opportunities. In addition, community political subdivisions and community organizations provide programs and facilities which can be capitalized on by the senior citizen.

Our Council strongly believes that our nation is the loser if we do not utilize the knowledge and skills possessed by millions of older citizens. These talented, untapped individuals with the advantages of life experience, specialized knowledge and skills, and the rare commodity of time are in a position to be of real service to society on environmental problems, economics, working with dropouts, tutoring, health services, and consultive work with business and industry.

We believe that our education system should not only provide services for senior citizens, but should also employ their talents. There is evidence today that American education is finding new ways of involving these citizens in setting up task forces and advisory council structures that tap the knowledge and skills of the aging and aged.

We are hopeful that this information and the Council's target population report will facilitate the focus of a spotlight on adult education as a resource for the senior citizen and in the study of various problems faced by your Special Committee on Aging.

Sincerely yours,

GARY A. EYRE, *Executive Director.*

ITEM 21. NATIONAL ENDOWMENT FOR THE ARTS

FEBRUARY 14, 1975.

DEAR SENATOR CHURCH: This is in response to your request for a statement about the major activities for the aging undertaken by the Endowment through our grant programs and projects in 1974 and 1975.

I am enclosing a summary statement on these activities for your reference in preparing the Special Committee on Aging's Annual Report to the Senate.

Please let me know if you have any additional questions or need any more supporting data. I hope that this information is helpful to you.

My very best,

Sincerely,

NANCY HANKS, *Chairman.*

[Enclosure]

A REPORT TO THE SENATE SPECIAL SUBCOMMITTEE ON THE AGING SUMMARIZING THE MAJOR ACTIVITIES IN THIS AREA BY THE NATIONAL ENDOWMENT FOR THE ARTS DURING FISCAL YEAR 1974 AND CONTINUING IN FISCAL YEAR 1975

Within the last 5 years, the scope of the programs assisted by the National Endowment for the Arts has been expanded to include a variety of community arts involvements which support the artist in new ways and help to broaden the audiences reached by these programs. Often opportunities for participation in the arts by the young, the elderly, the disadvantaged and our ethnically diverse population have been radically changed and enlarged through these programs. Those involving senior citizens have been organized with particular sensitivity in reference to their roles as participants, audience members and resource persons.

In September of 1973, the National Council on the Arts, which is the Endowment's advisory body, made an official resolution urging that the Endowment take a leadership role in making the arts more accessible to the physically handicapped. The response to the Council's resolution was quite enthusiastic, especially from our senior citizens who have physical difficulties making it difficult for them to take part in arts activities. As a result of the resolution, and in response to urgent and imaginative requests from the field, the Endowment has provided funds for a number of programs specifically concerned with enlarging the understanding of the special needs of our nation's senior citizens. For example:

The National Council on the Aging was awarded in Fiscal Year 1974 a grant in the amount of $25,000 for the continuance of the staff operations of the NCOA's Center for Older Americans and the Arts. The Center provides assistance to arts organizations in developing new programs at the local level to involve the elderly and works with the elderly to elevate the quality of their participation in the arts. It serves as a clearinghouse of ideas, programs and information and conducts workshops and seminars. The Center Director coordinated in September of 1973 a seminar on the arts during an NCOA National Conference held in Chicago, Illinois. The seminar represented the first time that the arts were included as a formal part of the NCOA's conference agenda. The Illinois State Arts Council and the Illinois Office of Services for the Aging co-sponsored the program. Additional workshops on the arts were held in Des Moines, Iowa, Los Angeles, New Orleans, and New York at NCOA regional conferences. We recently awarded the NCOA a Fiscal Year 1975 grant in the amount of $25,000 for continuing their efforts to broaden the arts constituency to include the elderly.

The Universty of Illinois received a grant in the amount of $15,000 in Fiscal Year 1974 to offer workshops for architects and engineers to study particular ways of making cultural facilities accessible to the physically handicapped, including the elderly.

Also in Fiscal Year 1974 the Endowment awarded a grant in the amount of $37,650 to the Easter Seal Society for Crippled Children and Adults of Massachusetts, Inc. for a survey of the architectural and related barriers to the physically handicapped on the Freedom Trail and other historical and cultural sites, and for recommendations for the elimination of such barriers.

In a recent survey of public opinion titled "Americans and the Arts" (conducted by the National Research Center for the Arts and funded in part by the National Endowment for the Arts), it was noted that there has been a dramatic drop in attendance at cultural events among older Americans, which may point to a potential and presently untapped market for cultural activities among senior citizens if some of their impediments to attending can be solved. For example, 56 percent of the 65 years and over group are classified as non-attenders, compared with 25 percent of the 35 to 49 year olds and 18 percent of the 21 to 34 year olds.

The same survey indicated that the expense of attending cultural events is clearly a consideration for many people, with 41 percent of the public agreeing that the total cost of attending was an important factor in cutting down on the frequency of attendance. In the under $5,000 income group, where many of the elderly fall, 11 percent of those surveyed said that they attend less because of the cost of attending. Other problems of the elderly surface in the study:

—23 percent said that decreased attendance was due to bad health;
—12 percent said that decreased attendance was caused by the difficulties of transportation;
—7 percent of the elderly attend less because they have "no one to go with and don't like to go alone."

Statistics on attitudes such as these indicate that not only are programs to help cut ticket costs important but so are ways of providing companionship and transportation, either by organizing senior citizens groups to attend functions, or by taking the artists or cultural groups to them (into old age homes, for example).

Many of the Endowment's community art programs directly affect the elderly. And, in the broadest sense, our ongoing grant assistance programs to orchestras, operas, dance troupes, theatre companies and museums, which help to reduce ticket prices overall, provide blocs of tickets at a lower cost, or make free activities available, are an obvious boon to those aging citizens who are pressed financially but are still interested in participating in the nation's cultural life.

Examples of some of our major activities follow:

In Fiscal Year 1974, the Endowment for the Arts awarded more than $7 million to symphony orchestras which included providing such services as those listed above, while employing over 10,000 musicians. Many orchestras developed programs which specifically provided free concerts for the elderly and underprivileged. The San Francisco Symphony performs neighborhood concerts; the Western Opera Theatre brings highly accessible performances throughout the west and has toured Alaska; the Rochester and Buffalo orchestras make special efforts to include both the elderly and the underprivileged in their concert schedules. The Florida Gulf Coast orchestra performs in Tampa and in St. Petersburg—both major retirement areas. The Milwaukee Symphony Orchestra in Fiscal Year 1974 received a matching grant of $140,000 which specifically included matinee concerts for senior citizens. The concerts were held in the afternoon when an older population could attend the concerts with greater ease.

In addition, our assistance to touring programs, particularly in dance and theatre, has helped to bring major arts organizations into communities throughout the nation to audiences who might never have been able to afford the travel costs to urban centers where these cultural groups may originate—such as Minneapolis, San Francisco, Salt Lake City and New York. During Fiscal Year 1974 our Dance Touring Program sent more than 60 professional dance companies into 51 states.

A major portion of our 9 million dollar Museum Program in Fiscal Year 1974 went to help make museum resources and activities far more available to the residents of the communities in which these institutions are located—these activities are often a major outlet for senior citizen interests. For example, the Maryland Historical Society has provided transportation and special guided tours of the Society for the elderly, under a Fiscal Year 1974 matching grant from the Endowment in the amount of $5,925.

The National Endowment for the Arts also provides assistance to community organizations which offer free or low-price tickets plus transportation to cultural events.

Such a program is Hospital Audiences, Inc., which gives extensive advisory services throughout the country to those who wish to follow their example of providing donated tickets to the elderly, the sick and the disadvantaged. For those who cannot attend such performances, Hospital Audiences arranges performances within the institutions. Our assistance to Hospital Audiences in Fiscal Year 1974 for these purposes amounted to $34,490 and has been increased to $55,000 in FY 1975.

Recently the Off Center Theatre, Inc., in New York City received an FY 1975 grant in the amount of $8,500 to tour the play "Chickens Come Home to Roost" to the elderly in thirty nursing homes.

In St. Paul, Minnesota, senior citizens are taking part in a new arts program designed especially for them through COMPAS (Community Programs in the Arts and Sciences), which is a member agency of the St. Paul-Ramsey Arts and Science Council and the Wilder Foundation. The Endowment provided COMPAS a grant in the amount of $15,000 for a series of arts workshops in pottery, dance, theatre, music, visual arts, film, writing and literature, to be taught by professional artists in the St. Paul area. In addition, efforts are being made to support the purchase of tickets by senior citizens to arts events in the area, and to provide special transportation.

The senior citizen as an artist—professional and volunteer—is also encouraged through the Endowment's programs. For example:

Our Visual Arts Program makes particular provision for a limited number of artists' fellowships to be set aside for senior (over 50 years of age) artists. In Fiscal Year 1974 five artists were helped by this provision with a total expenditure of $37,500.

Under our Expansion Arts Program's "Arts Exposure" category, a $7,500 matching grant was made to Danzas de Aquellas at the University of New Mexico, Albuquerque in Fiscal Year 1974. Its purpose is to promote cultural research efforts to learn and recapture the traditional music, dance and folk arts of New Mexico and other multi-cultural states. Senior citizens are called on as resource persons for these traditional expressions and as members of performing groups which tour the schools.

Each state has a state arts agency which receives basic support from the National Endowment for the Arts, and many of these agencies are helping with important programs for the aging, some of which received additional matching aid from the Arts Endowment. For example:

In Fiscal Year 1974 the Rhode Island State Council on the Arts hired a director to develop its arts and the aging program. The director organized a statewide conference out of which evolved a variety of projects to take senior citizens to museums, and to theatre, dance and orchestra performances; in addition, artists and groups were brought to nursing homes and hospitals. Also, participatory workshops were set up in music, ceramics, other crafts, writing and a three-day dance residency with Katherine Dunham. The workshop component reached over 2,000 people, with funding in the amount of $5,000 from the Endowment, matched by the Rhode Island State Council and $2,000 from other sources.

In Oregon, the Endowment and the State Commission supported an artist in residence program in Eugene to: (1) provide art education to the elderly; (2) help older individuals realize that they can make creative contributions to society; and (3) increase society's awareness of the older individual as a creative resource in our society. Free instruction, special workshops and demonstrations by visiting artists were given, and some 200 senior art students participated in field trips to museums and galleries and exhibited their work in local banks, recreation centers and parks.

In Washington, four workshops were held through the fall and early winter of 1974 at the Centrum Foundation, three of them to provide a variety of arts experiences, and the fourth to offer a specific writers' workshop for retired writers. The Endowment provided the state agency with matching funds of $4,000 for this project.

In Idaho, a pilot program was developed called "Arts for Idaho's Senior Citizen" which used the resources of Boise State University and the Idaho Office on Aging. The project engendered a film titled "The Seniors", which is available to other groups planning similar projects.

In South Carolina, the University of South Carolina received funds from the Endowment for the Center for Arts and Humanities Programming for Elders, providing areas for senior citizens to take part in projects in dance, theatre, music, filmmaking and the visual arts and including workshops (for example, a potter in residence specializing in Raku pottery).

In Kansas, a coordinator was funded to develop new projects in a variety of special areas, such as programs for education and the arts in prisons, inner city activity, American Indian reservations and old age communities. Our matching award in Fiscal Year 1974 amounted to $14,050.

In Iowa the Arts Council is offering a seminar/conference in March of 1975 to be titled "Career Opportunities for the Professional Artist" and among the topics for discussion is "Arts for Older Americans".

In Alaska, "mini-grants" were given to the Bethel Arts Council for a senior citizen audience development project, in which the local cab company donated free transportation to concerts for the older people of the community. The grants matched donations for the concert tickets.

In Delaware, a day long seminar was held in April of 1974 at the Wilmington Senior Center, introducing a fresh approach to the arts for the elderly.

In Mississippi, a pilot project begun in 1972 with some Endowment assistance, undertook a general active therapy program for the retarded and handicapped at the Ellisville State School. The program has continued and its work has been augmented with the help of retired senior volunteers who provide instruction in crafts, dance, theatre, visual, arts, music and creative writing.

Through the continuing efforts of the Endowment and the state arts agencies, we hope to encourage senior citizens to participate more directly in arts activities and to help provide them with greater accessibility to the performing and visual arts.

ITEM 22. NATIONAL ENDOWMENT FOR THE HUMANITIES

FEBRUARY 11, 1975.

DEAR SENATOR CHURCH: This is in response to your letter requesting a summary of our major activities on aging during fiscal year 1974 and our plans for continuing efforts in 1975.

In carrying out its Congressional mandate to encourage the understanding, use, and enjoyment of humanistic knowledge in the United States, NEH responds to the needs and interests of the humanistic community. It does not designate fixed amounts of money for work in any particular subject area or for any particular group of individuals, minorities, etc. The Endowment, therefore, has no program designed specifically to serve the aging. NEH, however, does encourage competitive proposals from organizations and individuals that show how the humanities relate to the problems of aging and how humanistic input can benefit the general public as well as those experiencing the process and problems of aging. I am pleased to describe briefly for you some of the projects in this latter area that the Humanities Endowment has supported.

For example, through our Division of Public Programs, which serves the general adult public not affiliated with educational institutions, NEH supported the Southwestern Michigan Consortium on Gerontology and the Humanities. This one-year project emerged from four months of extensive planning by community representatives, faculty and administration and reflected the expressed interest of a variety of concerned organizations and groups. Twenty faculty members from the humanities and social sciences as well as the public addressed themselves to questions of comparative social approaches to aging and the aged, the assumptions of the youth culture, the psychological implications of aging and attitudes toward death, how the aged have been viewed in literature, how society can best utilize the talents and abilities of senior citizens, and what alternate religious and philosophical approaches exist to face death.

Through our Division of Education Programs, which seeks to help educational institutions at all levels and of various kinds to improve instruction and make more effective use of resources in the humanities, the Endowment is helping Heidelberg College in Tiffin, Ohio, to develop and offer an interdisciplinary seminar, "The Aged in Our Society" at the junior-senior level. Among the topics pursued during the seminar were: the physical process of aging; the legal, ethical, and religious implications of euthanasia; the biological problems of the aged; the personal relationships among the aged and between the aged and younger people; and the nature of death.

The NEH Fellowship program allows an individual scholar the opportunity to pursue full time study or research in the humanities for periods up to one year. Among the topics NEH Fellows have examined during their tenure was "Aged Americans: Survey of a Minority Group", a literary and historical survey of elderly persons in American society with special interest focused on the causes and consequences of being designated an outsider.

The Endowment's Office of Planning is responsible for exploring new ways of acquiring and applying humanistic knowledge. Housed in this division is the experimental Program of Science, Technology and Human Values whose premise is that the humanistic disciplines can locate the developments in science and technology within the larger perspectives of the human enterprise. An award made through this program to Case Western Reserve, in Cleveland, Ohio, is enabling the detailed planning and preparation for a symposium which would introduce younger humanities scholars to research needs and opportunities on the subject of aging and the aged.

Located in this division also is the Youthgrants program, designed to support humanities projects initiated and conducted by students and youth generally under the age of thirty. This program has recently awarded a grant to the Learning Guild in Boston, a non-profit, mobile, educational group staffed by young persons from the city's many colleges and arts organizations. The Guild is traveling to thirty nursing homes in the greater Boston area offering two workshops entitled, "Jazz: An American Heritage" and "200 Years of American Art Forms". It is striving to provide for nursing home residents mental and physical stimulation, productive occupation of time and the resulting rise in self-esteem, recreation and activity for therapeutic purposes and re-education and/or learning of new skills. The Guild is emphasizing that these workshops are not temporary time fillers, but rather are the groundwork to motivate further study and to integrate these skills into daily life. The Guild is also attempting to train the director of the homes to motivate this interest in the humanities so that when the Guild leaves the home their tools are left behind.

I should also add that we are unable to estimate what our support will be in future years for activities related to the aged because the Endowment responds to, rather than solicits, inquiries and proposals initiated by individuals and organizations from all over the nation. NEH makes awards based upon first, specialist peer review, and, then, recommendations of the National Council on the Humanities, which, by law, must advise the Chairman regarding action to be taken on all applications submitted to the Endowment.

I hope you and your Committee will find this brief overview of our activities useful.

Sincerely yours,

Ronald Berman, *Chairman.*

ITEM 23. POST OFFICE DEPARTMENT

February 11, 1975.

Dear Mr. Chairman: In response to your December 20 request to Postmaster General E. T. Klassen, we are pleased to furnish for your consideration the following information relative to Postal Inspection Service activities of special value to our elderly customers.

The ability of the American consumer to confidently transact business by mail is vital to the national welfare. The mail is an essential artery of commerce and communication, and must remain sacred. No element of our society—particularly, the elderly—is immune to loss through mail fraud activity. Mail Fraud is characterized by guile, deceit, and concealment; its success does not depend upon the use of physical force, violence, or threats. Structured on man's natural tendency to trust his fellow man, frauds are often designed to be perpetrated on particular segments of society, the elderly, the unemployed, the poor, etc. Through vigorous enforcement of postal statutes, the Inspection Service seeks to protect the public from fraudulent promoters who would use the mails to further their schemes.

The Mail Fraud Statute, Section 1341, Title 18, United States Code, is the oldest "Consumer Protection Law" ever enacted by Congress. It provide for a fine of $1,000 or 5 years imprisonment, or both, for any use of the mails in furtherance of a scheme to obtain money, or property, on the basis of fraudulent representations.

During Fiscal Year 1974, the Inspection Service received 111,907 complaints of alleged mail fraud. Arrests by Postal Inspectors for mail fraud totaled 1,570 and 1,394 convictions were obtained. Some 4,293 questionable promotions were discontinued as a result of our investigations. Although the Mail Fraud Statute makes no specific provision for restitution, approximately $6.5 million was returned to victims.

Working with the Law Department of the U.S. Postal Service, the Inspection Service utilizes two administrative-civil actions; Sections 3005 and 3007 of Title 39 of the United States Code. Section 3005 permits the Postmaster General to withhold, and return to senders, mail addressed to anyone whose advertisements soliciting remittances are shown to contain false representations. The companion statute, Section 3007, makes it possible to obtain an order from a U.S. District Court which permits the withholding from delivery, mail addressed to such a firm or person, pending conclusion of Section 3005 proceedings.

On July 1, 1974, a new consumer protection program was implemented. It is designed to assist postal customers who complain of unsatisfactory mail-order transactions. Complaints received are reviewed to determine if a full investigation is warranted, or if action can be taken to resolve the customer complaint through direct contact with the mail-order houses. In either case, the customer is notified of the action taken. Direct contact with the mailer has been very successful to date. Many complaints resulting from poor business practices, overlooked orders, and the like, have been promptly resolved and postal customers have expressed their appreciation for the attention given.

All consumers, regardless of age, are adversely affected when a fraudulent scheme is perpetrated upon the community. While the variety of mail fraud promotions is virtually limitless and persons from all walks of life are potential victims, experience has shown that elderly consumers are particularly vulnerable to certain schemes. Perhaps a brief resume of some of these schemes, together with related statistics, will be of interest to your committee.

Business Opportunities

Four separate, but closely related promotions, fall within this category. Distributorships, franchises, vending machines, and other job opportunity frauds lure investors with promises of high returns and guarantees of success which later prove, for the most part, worthless. These rackets frequently victimize older people who hope to put their resources to profitable use. In Fiscal Year 1974, investigations were completed in 155 cases, resulting in the discontinuance of 88 questionable operations. A public loss of $32,552,735 was cushioned somewhat by the fact that 18 convictions were obtained and an estimated public savings of $3,412,531 was effected.

Vending machine routes, advertised to require only part-time attention, are particularly attractive to older retired persons. Recently, an operator of this type promotion in the Mid-West induced 34 persons to invest $127,000 in area distributorships. The defendants converted the money to their personal use and the investors received no vending machines at all.

CHAIN REFERRAL SCHEMES

These schemes are aimed directly at low-income consumers and the elderly are particularly susceptible. Fast talking salesmen pass off desirable, but grossly overpriced, appliances and home improvement items under the misrepresentation that the products will actually cost nothing. The victim is requested to supply names of friends and associates as potential purchasers and thereby earn commissions. Not until they have signed conditional sales contracts and other documents, do the victims realize they have actually obligated themselves to pay for a product which they often neither want nor can afford.

During Fiscal Year 1974, 131 investigations caused the termination of 98 chain referral schemes. Public loss in these cases amounted to $4,999,402. Public savings as a result of the discontinuances are estimated at $306,635.

HOME IMPROVEMENT

This type of fraud is generally directed at the uninformed owners of modestly priced homes. Elderly citizens are often physically unable to make repairs themselves, and can be convinced that their property is badly in need of expensive renovation. Likewise, such items as aluminum siding, porches, patios and garages, etc., are attractive to retired or semi-retired individuals who desire to make their homes as comfortable as possible.

Of late, a group of versatile fraudulent operators offered home improvements of all types. Convicted of mail fraud, they received substantial prison sentences. The scheme, which was in operation for about a year, involved contracts obtained through fraudulent representations, the use of fictitious names and even disguises. Public loss of approximately $220,000 was incurred by home owners and loan companies.

LAND SALE SWINDLES

The purchase of land for a retirement homesite is an attractive investment for senior citizens. Unfortunately, some promoters misrepresent the property they have for sale. Unfinished developments, swamp lands and barren desert plots, may be foisted on an unsuspecting purchaser.

One noteworthy case involved a remote desert area of Mohave County, Arizona, which was sold off in lots under the name "Lake Havasu Estates" (no connection with Lake Havasu City). Through false claims, that an interstate highway from Phoenix to Los Angeles was under construction on the land; that the Ford Motor Company and singer Eddie Fisher had purchased large tracts for industrial development; that the owners owned the relocated London Bridge; and that purchasers who were not satisfied after veiwing their lots would receive full refunds, victims were enticed to pay from $3,000 to $5,000 per lot. Over $6 million was lost. Eight officers of the company were convicted of mail fraud and sentenced to serve a total of three years, seven months, in prison, plus eight years on probation. A $10,000 fine was also assessed. The president of the company received the heaviest prison sentence—two years. Investigations by the Postal Inspection Service concluded in 17 land sale promotions of this type being discontinued during FY 1974, and conviction of 11 operators. An estimated public savings of $13,542,800 was achieved.

MATRIMONIAL SCHEMES

Lonely people, including the elderly, are often swindled by dishonest persons. Men and women seeking pen pals, with a view toward finding suitable mates, frequently join lonely hearts clubs. Few, if any, of these clubs have facilities for investigating the people who apply for membership and it is said that a list of members can be purchased with little or no difficulty. Club membership lists are, therefore, sometimes obtained by unscrupulous persons who use them to carry on extensive correspondence with prospective victims. The correspondence is usually started by the promoter's misrepresenting himself to be exactly what the club member desires in a mate. As the correspondence continues, endearing terms are used, and when the prospective victim mentions matrimony, his or her pen pal responds with talk of current financial problems. There will generally follow a request for money to carry the loved one over the temporary crisis. Once the money is received, the promoter ignores additional correspondence, or returns the letters marked "moved, left no address." Obviously, many victims are hesitant to report the matter because of embarrassment.

MEDICAL FRAUDS

By nature, medical frauds probably affect the elderly more than any other portion of our population. Today, despite up-to-date medical facilities and warnings published in every media in almost every community, elderly people fall prey to medical quacks. These charlatans depict, by means of cleverly designed advertisements, cures for a long list of geriatric problems, including arthritis, cancer, obesity, impotency, and headaches. Rapidly rising medical costs and lack of sufficient insurance coverage, among other circumstances, influence the elderly to try these quick cures. On the surface, these remedies appear to be much lower in cost, and require little more than the placing of an order. The huckster's spiel, that his nostrums reduce cost of medical care, is difficult to believe, in view of the fact that in this field the known public loss for Fiscal Year 1974 was over $9,000,000.

In addition to prosecution, many medically related schemes are thwarted by timely action by the U.S. Postal Service. This action, under 39 U.S. Code 3005, may result in orders being returned to the senders, effectively stopping the promotion. Such was the case recently with a company claiming a cure for arthritis, wherein the product furnished was a dietary regimen. In establishing the fraudulent nature of the representations made, the Inspection Service obtained expert medical testimony to the effect that no one treatment is available for all forms of arthritis and the treatment furnished would do no good whatsoever.

Some medical fraud schemes include representations that are not only false and misleading, but may also be considered dangerous. One company, in particular, claimed to have developed a plan that would cure the flu overnight; was a means of preventing oral cancer; would assist in extending the average age to 100; would prevent maiming diseases, and still cost less than $25. Much of the information contained in the plan could cause additional problems, rather than relief.

Also, reliance on the use of the mail order cure would certainly delay the victim's seeking competent medical advice. Prompt Inspection Service action put this company out of business. Investigations brought about the discontinuance of 133 questionable promotions in the medical fraud category in Fiscal Year 1974.

SOLICITATION OF FUNDS

Thousands of organizations solicit funds from the public, and appeals for contributions extend to many causes and include an endless variety of charities and betterment organizations. Elderly people who have experienced life's problems are often anxious to assist those less fortunate than themselves. In some instances, this involves reducing an already meager income by that much more. Unfortunately, funds solicited by unprincipled promoters funnel into the hands of swindlers. Schemes of this type vary, but all have one thing in comon—they prey on the sympathy and the desire of many to help the unfortunate. Unauthorized assumption of the names of legitimate charitable organizations, as well as the use of bogus and official sounding titles, are some of the ploys used by the con man. A fraud operator needs little more than a solicitation letter and a mailing address to set up his business.

There were 147 cases issued for investigation by the Postal Inspection Service in the area of solicitations, in general, during Fiscal Year 1974, and of this number 64 promotions were discontinued.

WORK-AT-HOME SCHEMES

Retirees, invalids, housewives, and others, particularly in the poor and lower middle-class income levels, frequently desire to supplement whatever income they have. Age, health and family responsibilities may make it impossibe for these persons to hold even a part-time job. Naturally, the prospect of employment at home is attractive to them.

A mail-order promoter in Philadelphia, Pennsylvania, was recently convicted of operating a work-at-home scheme in which the public loss was approximately $70,000. The business consisted of soliciting money through the mails in return for a "work-at-home" kit which contained letters of solicitation to be sent to new victims. The letters acted as a self-perpetuating mechanism, since the victim was advised to duplicate the operation on his own.

Investigations of 132 such promotions resulted in 100 work-at-home schemes being discontinued during Fiscal Year 1974. The public savings resulting from these investigations is estimated at $150,787.

PUBLIC EDUCATION AND FRAUD PREVENTION PROGRAMS

The Postal Service is vitally interested in the protection of the public which can be enhanced by increased consumer awareness. The Mail Fraud pamphlet attached is available on request, as is a similar publication in Spanish.

The Postal Inspection Service also maintains close liaison with other federal, state and local agencies having a concern for consumer protection. In addition, Postal Inspectors made over 1,000 speaking appearances before various law enforcement, civic, education, and consumer groups this past year. Although, in most cases, our investigations are "after the fact situations," our programs are also directed at prevention, and we are continually seeking new ways of developing greater public awareness of fraud danger signals.

I hope this summary will be helpful to you and your committee. If we can be of further assistance, please do not hesitate to contact me.

Sincerely,

NORMAN S. HALLIDAY,
Assistant Postmaster General,
Government Relations Department.

ITEM 24. RAILROAD RETIREMENT BOARD

JANUARY 28, 1975.

DEAR MR. CHAIRMAN: With reference to your letter of December 20, I am pleased to enclose a statement summarizing major activities of the United States Railroad Retirement Board on aging during 1974. It is anticipated that payments under the Railroad Retirement and Unemployment Insurance Acts will be somewhat higher during 1975 than in 1974.

We look forward to your committee's 1974 report on developments in aging.

Sincerely yours,

R. F. BUTLER, *Secretary.*

[Enclosure]

U.S. RAILROAD RETIREMENT BOARD

The U.S. Railroad Retirement Board is the Federal agency that administers a social insurance system, separate from but coordinated in several ways with Social Security, for railroad workers and their families. Programs of the system include the following: (1) old age, survivor and disability benefits under the Railroad Retirement Act and (2) unemployment and sickness insurance benefits under the Railroad Unemployment Insurance Act. In addition, certain administrative services under the Federal health insurance (Medicare) program are performed with respect to aged and disabled railroad workers.

DEVELOPMENTS IN 1974

LEGISLATION

The Railroad Retirement Act of 1974, enacted October 17, 1974 as Public Law 93-445 and effective January 1, 1975, completely restructures railroad retirement benefits. The legislation was developed by a joint committee of railroad management and labor representatives, and was intended to put the railroad retirement system on a relatively sound financial basis, make certain improvement and preserve the existing equities of career railroad employees. The actuarial deficit was reduced from more than nine percent of taxable payroll to less than one percent on a level basis. Major provisions of the Act include:

(1) A revised regular employee annuity formula, consisting primarily of two tiers. One tier is computed in the same way as a social security benefit, using the employee's combined railroad and social security earnings. Any social security benefit the retired employee is paid will be subtracted from the tier 1 amount. The second tier is a staff type benefit based solely on railroad service and compensation.

(2) Supplemental annuities payable to employees who with 30 or more years of railroad service retire after June 1974 at age 60 and older. For those who retired before July 1974, or who have 25–29 years of service they remain payable at ages 65 and older. The supplemental annuities will be for smaller amounts, ranging from $23 based on 25 years of service to $43 for 30 or more years, but there will no longer be an offset made for them in the regular annuity computation. Thus the total benefits will be substantially the same or higher.

(3) A full spouse annuity is payable at age 60 to the wife of a retired employee age 60 or older with 30 or more years of service if the employee's regular annuity began after June 30, 1974. For an employee age 62–64, with less than 30 years of service, whose regular annuity begins after December 31, 1974, the new law lowers the age required of such an employee for his wife to be eligible for a spouse annuity. In 1975 or later, the employee need only be age 62 for his wife to receive a reduced annuity at age 62 or a full annuity at age 65. The wife's tier 1 amount will equal one-half of the employee's tier 1 before reduction for his social security benefits. Her tier 2 amount equals one-half the employee's, subject to the limitation that tier 1 and tier 2 cannot total more than 110 percent of the largest amount that social security could pay as a spouse benefit. Social security benefits received by the wife are subtracted from her tier 1 amount.

(4) A "grandfather" clause, which guarantees that employees and their wives retiring during the eight years following 1974, will receive no less than the amount that would have been payable under the previous railroad retirement provisions, excluding social security benefits.

(5) An increase in most survivor benefits, which is also calculated using a two tier formula, effective January 1, 1975. The calculation basis for survivor annuities is 130 percent of the amount social security would have paid if the beneficiary had been covered by that system. Previously, they had been guaranteed 110 percent of the social security amount and the majority of survivor beneficiaries were paid under this guaranty.

(6) "Windfall" dual benefit to employees, spouses and survivors who meet certain criteria deemed necessary for "dually vested" status under both the railroad retirement and social security systems. The benefit replaces, at least in part, the offset in tier 1 amounts for the receipt of social security benefits. This is a temporary feature of the system meant to give allowance for social security service prior to 1975. The cost for this provision will be met by the general funds of the Government.

(7) Cost-of-living increases for both tier 1 and tier 2 benefits. Tier 1 benefits will be increased in the same way and at the same time social security benefits are increased and survivor tier 2 benefits will be increased proportionately. Four cost-of-living increases in tier 2 retirement benefits are provided during the next six years.

(8) A tax refund, for employees who are not entitled to windfall dual benefits, for any excess social security taxes they paid on his combined earnings under both systems for years after 1950 and before 1975. The refund will be paid to the employee upon his retirement or to survivors if he dies without having retired. For years after 1974, any railroad employee paying excess retirement taxes may apply for a refund on his income tax return.

(9) Gross residual lump-sum death benefits are frozen to the amount accrued through 1974 and insurance lump-sum for employees with 10 or more years of service before 1975 will be based on that pre-1975 service. For others, the insurance lump-sum will be equal to the amount payable under social security, presently $255.

(10) In effect the temporary increases in railroad annuities of 15 percent, 10 percent and 20 percent enacted by Congress in 1970, 1971 and 1972, respectively, are made permanent.

BENEFICIARIES AND BENEFITS

During fiscal year 1974, benefit payments under the railroad retirement and railroad unemployment insurance programs totaled $2,721 million, an increase of $191 million from fiscal 1973. In addition, payments of $275 million for hospital insurance benefits and $86 million in supplemental medical insurance benefits were made on behalf of railroad workers covered under the Medicare program.

Retirement and survivor benefits amounted to $2,671 million, almost nine percent higher than the total in fiscal 1973. However, unemployment and sickness payments in the year totaled $50 million, almost one-third less than in the previous year.

In the course of the year, 1,073,000 individuals received benefits under the retirement-survivor benefit programs. The vast majority (over 80%) were aged 65 and over. Almost 446,000 retired employees were being paid a regular annuity of $297, almost $28 higher than a year earlier. In addition, 116,000 of these employees (30% of all retired employees age 65 and over) were being paid supplemental annuities averaging $66. Some 210,000 wives, received an average annuity of $142. Of the 333,000 survivors on the rolls as of June 30, 1974, over 286,000 were aged widows receiving an average annuity of $183. About 860,000 persons who were receiving or were eligible to receive monthly benefits under the Railroad Retirement Act were covered by hospital insurance under the Medicare program at the end of fiscal year 1974. Of these, 837,000 (97%) were also enrolled for supplemental medical insurance.

Benefits under the Railroad Unemployment Insurance Act were paid to 113,000 railroad employees. However, less than $1 million (1.6%) of the benefits went to individuals aged 65 and older.

ITEM 25. SMALL BUSINESS ADMINISTRATION

JANUARY 13, 1975.

DEAR MR. CHAIRMAN: This will acknowledge your request with reference to the Annual Report of the Senate Special Committee on Aging.

The services of this Agency are available to small businessmen regardless of age. However, we do not categorize borrowers by age and cannot report numbers of loans approved by age of clients.

Our disaster loan program is particularly helpful to older citizens who are injured by natural phenomena. It is Agency policy that age not be a factor in any disaster loan application decision. If an elderly person's home is destroyed in a disaster, all other things being equal, he receives a disaster loan as rapidly as a younger person.

For our other lending programs, age, in itself, is not a prohibiting factor in receiving loan approval. By legislative mandate, we must have reasonable assurance that the loan can be repaid before we approve any loan and, in some instances, the age of the owner(s) of the business may play a role in determining repayment ability. However, we have and will continue to administer all of our loan programs without regard to age, creed, color, sex, or national origin.

We coordinate the efforts of many senior citizens through the SCORE (Service Corps of Retired Executives) Program. SCORE is an organization of retired business executives who volunteer their services to help small business owners solve their problems. The collective experience of SCORE volunteers spans the full range of American enterprise. We have 5,200 volunteers at the present time during FY 1974 these volunteers did approximately 60% of the total counseling to small business, and we expect it will increase to 70% during FY 1975. We value this contribution to small businesses by our older citizens.

With all good wishes.

Sincerely,

THOMAS S. KLEPPE,
Administrator.

ITEM 26. VETERANS ADMINISTRATION

FEBRUARY 10, 1975.

DEAR MR. CHAIRMAN: In response to your request of December 20, 1974, I am pleased to forward the enclosed report on Veterans Administration activities relating to developments in aging for the year 1974.

As you know, this Agency has a significant interest in our aging population. Over two million of the more than 29 million veterans in this country are 65 years of age or older, and more than one half of all veterans have passed their forty-fifth birthday.

The magnitude of our activity is indicated by the fact that currently the VA provides all or part of the income of more than 1.6 million persons age 65 or over. Also on a "typical" day in the VA-supported inpatient institutions (i.e., hospitals, nursing homes, and domiciliaries) more than 32 percent of our inpatients—about 36,400 veterans—are age 65 and over.

Our involvement in a number of important geriatric research studies which hopefully will result in improving the health and living capabilities of our older population is continuing with increased interest and activity.

I hope that the enclosed information will be helpful to the committee. Please let us know if we can provide any further aid.

Sincerely,

RICHARD L. ROUDEBUSH,
Administrator.

[Enclosure]

VA ACTIVITIES AFFECTING OLDER VETERANS IN 1974

DEPARTMENT OF MEDICINE AND SURGERY

I. INTRODUCTION

The strength and impetus of the Veterans Administration's program for the aging has significantly increased in 1974. The commitment by all services and divisions of the agency has been strengthened as evidenced by the VA's commitment to the "Working Agreement on Information and Referral Services for Older People Among Federal Departments and Agencies."

Within the Department of Medicine and Surgery, there have been established six Geriatric Research and Clinical Centers involving eight hospitals and an outpatient clinic. Funding has been provided for establishment of an ongoing core cadre and additional funds are being released as specific projects for clinical demonstration and research are submitted and reviewed. A strong educational component is being prepared both for the Geriatric Research and Clinical Centers (to be renamed Geriatric Research, Educational, and Clinical Centers) as well as the VA as a whole. The targets of this effort include VA Health Care Professionals at the Centers, secondly, a broad group of VA personnel at other hospitals and clinics, and finally, the geriatric care community as a whole.

The Administrator of Veterans Affairs through his designee, the Deputy for Clinical Services, has continued to cooperate fully and actively with the Interdepartmental Working Group on Aging through its various subcommittees, notably, in research, nutrition, energy, and information and referral. The VA has made contact with the Duke Center for the Study of Aging and Human Development and the Faye MacBeath Institute of Aging while keeping in communication with the Ethel Percy Andrus Center of University of Southern California, and the all-university gerontology institute of Syracuse University.

A new development was the production of a conference at Baltimore in June 1974 on the subject of "Impact of Nursing Home Environment on Behavior of Older Patients." This conference brought together architects, engineers and design personnel with health care personnel such as physicians, nurses, social workers, dietitians, administrators, and therapists to critique the design of new VA nursing homes now being designed or built. The conferences on "The Caring Environment—Death and Dying" were continued at St. Louis VA Hospital. Additional conferences will be held next year.

In our clinical programs 19,220 aged veterans over 65 were treated in VA hospitals on a typical day last year. Additionally, more than 379,000 veterans aged 65 or older were provided ambulatory care services during the year. Five new outpatient clinics were opened during 1974 at Columbus, Ohio; El Paso, Texas; Chattanooga, Tennessee; Mobile, Alabama; and Orlando, Florida—a real boon to the aged veteran.

In our long term care programs, the number of veterans age 65 or older on a typical day were: 4,167 in VA nursing homes; 3,482 in community contract nursing homes; 3,000 in VA domiciliaries; 716 in state hospitals (VA supported); 3,224 in state nursing homes (VA supported); and 2,635 in state domiciliaries (VA supported).

Construction programs affecting the aged program went forward in 1974. The VA nursing home at Long Beach, California was completed and work is in progress on nursing homes at Iron Mountain, Michigan; Sepulveda, California; and Tuscaloosa, Alabama.

2. MEDICAL SERVICE

Medical Services in VA hospitals are responsible for approximately one-third of the total number of operational beds in the system. One-fourth of all patients in VA hospitals on a given day are aged 65 or older. While the average general medical and surgical patient in VA hospitals receives 22.4 days of care, patients over 65 show a progressively increasing length of stay from an average of 25.8 days for the age group of 65–69 to an average of 43.2 days for those patients 85 years old or older. These statistics illustrate two principal points: aging patients tend to manifest chronic diseases requiring longer periods of hospitalization and many of these patients are to be found on Medical Services, frequently in what is termed Intermediate Sections, which are staffed and equipped for the needs of longer-term patients, especially for those with hospitalization in excess of 30 days. Moreover, as the largest group of American veterans from World War II become older, (now 53.5 years on the average) VA can expect even a greater incidence of long-term illness arising from this group.

Heart, stroke, cancer and renal diseases continue to be the principal causes of death among adults in this country. VA is making significant effort to improve care of all veterans with these conditions, which per se affect a large proportion of aging patients. VA plans to complete its programs for installing specialized intensive care, coronary care and respiratory care diagnostic and treatment capability in all its hospitals by the end of FY 76. The VA dialysis program for end-stage kidney disease continues to grow and more aging patients are being accepted for long-term dialysis treatment. Hypertension, one of the principal underlying causes of heart disease, stroke and kidney failure, is the target of a major VA detection and treatment program which will be expanded in another dozen VA hospitals in the coming year. Successful implementation of the hypertension screening and treatment program should do much to ameliorate major causes of disability and death in the aging veterans.

Several programs which should have further impact on care of the aging veteran are under study or beginning to develop in VA. Examples are improved methods of diagnosing and treating infectious diseases (pneumonia and kidney infections continue to be major problems in the older age groups); clinical pharmacology, involving more appropriate use of medications; and rheumatology, which is concerned with arthritis and related bone and joint conditions—one of the major causes of discomfort and disability among the elderly.

Medical Services in the VA are committed to greater emphasis on ambulatory care as a major element of a comprehensive care program for veterans. In addition to broader services, greater use of ambulatory care as an alternate to hospitalization should yield significant cost avoidances. A side benefit of shorter or obviated hospital stays will be reduction of hazards of hospitalization such as hospital acquired infections and accidents.

Finally, Medical Services have a keen interest in rehabilitation, especially those developing programs aimed at restoration and improvement of heart and lung function—problems to which the aging patient is particularly vulnerable.

3. MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE

Progress in the development of several Geriatric Clinical and Research Centers is described in another section of this report. An attempt is being made in each of these Centers to attain an appropriate balance in efforts toward improved clinical practice and research in the social and psychological aspects of aging as well as the biological dimensions. Some Centers are, therefore, concentrating on methods of maintaining, to the extent possible, the important functions of orientation, alertness, motivation, and meaning and purpose in living in order to enhance the feeling of dignity in each individual.

Much has been written about the treatment of mental disorders in the elderly particularly in the area of chemotherapy. Additional data to augment the sparse information on the actual treatment administered to elderly patients are a prerequisite to evaluation of patient care. A survey was conducted in 12 Veterans Administration Hospitals on all patients 60 years of age or over as part of the initial assessment of patient populations in potential Geriatric Clinical and Research Centers. In addition to documenting the frequency and kinds of psychoactive drugs given to elderly patients and their relationship to diagnoses, this survey also demonstrated the need for well controlled studies comparing psychoactive agents in both organic brain syndrome and functional mental disorders. Studies are also needed to provide more information on the optimal dose levels for these drugs. It is hoped that this survey will provide the impetus, direction, and empirical foundation for such studies. It is also hoped that this survey will stimulate clinicians to re-evaluate drug prescription practices.

Another way in which effective programs for elderly veterans can be developed is through continuing education of staff personnel who work with geriatric patients. Last year one such effort was highlighted during the 19th Annual Conference of Veterans Administration Studies in Mental Health and Behavioral Sciences held in New Orleans, March 20–22, 1974. A major symposium at that conference was entitled "Brain Function and Age: Biological and Behavioral Aspects." Biological, behavioral, physiological and neurological implications for aging were described. Additionally, at the same conference, a teaching seminar was presented entitled "Senility vs Senescence: Are There Diseases of Aging or is Aging a Disease?"

Attempts to learn more about the characteristics of elderly veterans, research, and education and training of staff personnel will be continued by the Mental Health and Behavioral Sciences Service during 1975 to improve the delivery of health care services to aging veterans.

4. SOCIAL WORK SERVICE

Social Work Service has a long tradition of providing a wide range of services to the older veteran and to his wife or his widow. This is due in part to the fact that the veteran population is essentially an aging population and because medical science and technology have made it possible to live longer lives than ever before. The challenge to social work has been to help older veterans live meaningful and useful lives within the limits of their health problems and their disabilities. A complicating factor in achieving that has been a lack of adequate social services and social supports for older veterans in the community and the need to locate and develop a variety of resources including income maintenance, ambulatory health services, housekeeping and other personal services, meals on wheels, transportation, recreational opportunities, etc.

For those veterans requiring long term care, there has been a need to humanize our nursing homes and other special institutions, to create more caring environments which are responsive to individual needs and problems and encourage social interaction and independent decisionmaking.

In addition to helping older veterans with practical difficulties, Social Work Service offers counseling programs in such areas as retirement planning, loss of a loved one, developing of avocational interests, coping with feelings of discouragement, building a new life, and accepting the need for supervised living arrangement when independent living is no longer medically or socially feasible or desirable.

During FY 1974, Social Work Service assisted 21,779 veterans from general hospitals find community alternatives to hospitalization by placing them in personal care homes, domiciliaries, nursing homes, state soldiers' homes, boarding homes and other special placements. Seventy-one percent of these veterans were 60 years of age. Forty-eight percent were over 70 years.

Special attention is devoted to ensure that all community homes used by the VA meet quality standards and to this end Social Work Service along with other involved disciplines regularly inspects each home being utilized. In addition, Social Work Service carries major responsibility for providing continuing supportive services to these veterans after they have been placed in community care homes. Ongoing guidance, consultation, and training is also provided for the sponsors of homes to ensure that they are able to meet the needs of these veterans.

In May 1974, Social Work Service, in collaboration with the University of Georgia School of Social Work and with other professional services arranged a multidisciplinary workshop to explore community alternatives to institutional care for the older veteran. Further educational opportunities will be arranged periodically in the future in a continuous effort to upgrade and expand the knowledge and skills of those working with the older veteran.

Several new programs have been developed recently to serve veterans returning to their homes. Veterans who live in isolated areas or who live alone are being contacted by telephone at specified times by volunteers to insure that they are all right. This program is known as Telecare. Social workers in over 100 hospitals are supervising such programs or referring appropriate veterans to similar programs operated by other community agencies. Friendly visiting programs of volunteers to aged veterans who are homebound or residing in community nursing homes is another service offered by many of our VA hospitals.

The Geriatric Day Hospital is another pilot program which will be started in a few of our hospitals in FY '75 and expanded when funds become available. A feature of this program is a bus which accommodates wheel chairs and will be used to transport patients to and from their homes.

Counseling programs on Death and Dying have been expanded this year and there has been an increased emphasis on improving the quality of terminal care. Special attention is being given to helping hospital and nursing home staffs as well as patients and relatives understand and deal with their anxieties, fears, and frustrations in dealing with death.

Social Work Service plans to increase its involvement with university geronotological centers, schools of social work and community agencies concerned with the aged in the areas of service delivery, training, and research. Continuing emphasis is being placed on regionalized approaches to the care of the aged and to upgrade social support systems which will assist the aged in maintaining appropriate living situations in the veteran's own community.

5. REHABILITATION MEDICINE SERVICE

Emphasis on treatment and activity programs for older veterans remains a high priority item in RMS. There is a broad range of programs in various VA hospitals, specifically concentrating on not only rehabilitation of the geriatric patient, but for those patients needing continued hospitalization. Major stress is placed on creating an environment in which the elderly patient feels a useful, contributing member of society.

The list of programs includes involvement in Headstart or similar community programs in which the older patient has contact with children, Compensated Work Therapy, Reality Orientation, Remotivation Therapy, conjoint programs with local community agencies, activities of daily living programs in which the older veteran is encouraged to be as independent as possible in his personal care, and many others.

The Director, RMS, in VA Central Office serves as a member of the advisory committee to the American Hospital Association Reality Orientation project. The Reality Orientation training materials developed by the Project have been tested and are now available for release. Tuscaloosa VA Hospital continues to be a focal point for Reality Orientation training with periodic workshops held for VA personnel throughout the country. In addition, the Reality Orientation training staff shares their knowledge and expertise on the subject through presenting training programs sponsored by nursing home associations throughout the U.S. and into Canada. RMS personnel have expanded the use of Reality Orientation in treatment programs on Nursing Home Care Units and intermediate care wards throughout the VA health care system. The Director, RMS, also serves on the teaching faculty for the VA Nursing Home Care Unit training programs for supervisors teaching Reality Orientation Concepts.

A noteworthy example of a hospital/community project for elder patients is the St. Cloud VAH-Westwood School Remotivation Project. The program was singled out by the American Psychiatric Association for one of its Hospital and Community Psychiatry Gold Achievement Awards. A video tape and booklet of the program have been prepared and are available for viewing. An indication of the ongoing value of the program is the fact that it is in its fourth year and is enthusiastically anticipated by the sixth grade students at Westwood School and patients at the VA hospital. Although started by RMS, the program is a multidisciplinary effort with active participation with Nursing, Engineering, Dietetics, and other hospital Services.

Special geriatric exercise programs continue to develop. An especially good example is a swimming program for older patients developed at VAH Cleveland. It operates throughout the day and provides gentle exercise and hydrogymnastics for the geriatric patients. It has had high remotivation results.

Educational Therapy staff have been involved in various motivational activities, particularly planned around current events discussions in order to keep the older patient currently aware of world events. These discussions are often animated and provide an opportunity for the patient to share with his peers his knowledge and world experiences. In addition, excellent use is made of senior citizen volunteers to be involved with patients in these discussions. Patients at some hospitals attend adult education programs in the vicinity—VA Center Prescott is an example of this in which some of the geriatric patients attend the local community college.

VACO–RMS staff are involved in planning conferences for the Geriatric Research and Clinical Centers being developed in the VA.

Many RMS programs are being planned to involve both the veteran and his immediate family members in programs—especially those involved in integrating patients into community programs. A significant area for RMS is the extension of services into the community to help inpatients and outpatients identify the availability of community resources.

As more is known about the attitudinal and life-style characteristics of the older patient population in the various facets of the VA health care system, RMS joins with other Services such as Mental Health and Behavioral Sciences, Nursing, Social Work, and Voluntary to plan and carry out a broad range of dynamic programs in which the older veteran can use his various skills and interests to the maximum.

6. DIETETIC SERVICE

The nutritional care component of aged veterans' total treatment takes into account not only nutrient requirements in relation to specific disease entities but the emotional impact of food and the diet modifications necessary to meet an individual's socio-economic status. Food acceptance of the aged veteran is most important in assuring that he consume a nutritionally adequate diet. New food products are tested at individual VA hospitals and at the VA Dietetic Laboratory, Washington, D.C., to keep informed of highly acceptable food items that could meet the nutritional needs of veterans. Flavor, texture and appearance are especially important factors concerning food acceptance of the aged. Loss of sensory acuity makes distinctive flavors more desirable. Dental problems causing faulty mastication require diet modification in the texture of foods to prevent indigestion and even choking from swallowing foods before they are properly chewed and digested in mouth. Despite the need to adjust menus for texture, care is exercised to keep food in an as appealing a form as possible and to serve it attractively.

Food service systems are continually studied to provide the best possible quality of food to aged veterans. Special heat retention devices are used in meals served to aged patients who are apt to take longer in feeding themselves or who must be fed by nursing assistants. Prosthetic devices and adjunct aids to tableware are used by veterans suffering from the infirmities of the aged such as paralysis, tremors, and failing eyesight. Meals are served in day dining rooms to aged veterans in Nursing Home Care Units and other long term care patients, to foster the resocialization, improved morale, and rehabilitation that result from dining at tables and in the company of others as opposed to the isolation of a lone tray at the patient's bedside.

In an effort to assure continuity of adequate nutritional care of aged veterans following discharge from the hospital, VA dietitians individualize the nutrition education program to meet the patient's specific needs. Whenever possible, the patient's family member (caretaker) is also instructed on his nutritional care. Diet modification information is supplemented with food budgeting, shopping, and proper food preparation and service instructions. For veterans who are placed in community nursing homes, foster homes, and other personal care homes, the dietitian provides written diet instructions for home sponsors to follow. The dietitian is a member of the inspection team who reviews such community homes for veterans for sanitation, nutritionally adequate meals, and proper food preparation and meal service.

Another link with the community are the resources of the programs sponsored by the Administration on Aging. Dietitians keep apprised of such resources as "meals-on-wheels" and programs in which meals are served in congregate dining areas. Aged veterans, particularly those who live alone, are referred to these community nutrition resources upon discharge from the hospital. Such programs assist in maintaining the aged veteran in a satisfactory nutritional state. This year, the VA has communicated with the fifty State Commissioners on Aging who administer these programs to apprise them of the nutritional care benefits which aged veterans may receive in VA hospitals and out-patient clinics. This communication was designed to inform those people working closely with the widespread AoA programs in the community and to enlist their aid in bringing this information to aged veterans in need of professional nutritional care.

Future plans of the Dietetic Service include participation in the activities of the six new VA Geriatric Research and Clinical Centers. There is a desperate need for nutrition research in aging. Studies in these Centers will be directed to researching the nutritional needs of the aged in relation to metabolic changes and requirements, innovative approaches to assuring the aged veteran's total nutritional care in relation to his rehabilitation program prior to discharge and in follow-up care, and methods of improving nutrition in relation to health care delivery systems.

7. NURSING SERVICE

Nursing Service continues to utilize the team approach to planning and providing individualized nursing care for each veteran patient. This approach has proved successful in the past. It has been enhanced by collaboration and coordination with other disciplines on the treatment team to assure that all therapeutic activities are directed toward the same goals for the specific veteran. Nurse administered units are established in selected long-term care settings, in which nurses practice in an expanded role and assume primary responsibility for the continuum of care in health maintenance, management of symptoms, and referral to alternate care settings.

The written patient care plan includes an assessment of each veteran's nursing needs and a plan of action. The plan assures maximal attention not only to those needs related to care during the illness, but also to health teaching and supportive assistance for the veteran and his family. The focus is on the individual veteran's potential for independent functioning, the maintenance of this level, and the maintenance of wellness. A plan is developed for each patient in all VA care settings.

Reality orientation, remotivation, resocialization, and therapeutic recreation are integrated into daily programs involved with care for the aged veteran. Reality orientation in some long-term care settings has been adapted to include reorientation to functioning in the contemporary social and physical environment. Trips to laundromats, dry cleaning establishments, department stores, public libraries, entertainment areas, restaurants, railroad stations, airports, are diversional activities which also motivate improvements in personal hygiene and grooming, bridge the gap between institutional and community living, and add to the quality of life.

The patient and his family participate in planning his care in many settings. Nursing Service, in discharge planning, teaches the patient, the family, or other health workers including community health workers to care for the patient in the home or other setting. When medically indicated, Nursing Service provides for followup visits to the home through referral to community nursing agencies and orients community health agency workers or the community nursing home staff to the care of a specific patient. VA nurses also participate in surveys of nursing homes and make followup visits to these homes to assure satisfactory adjustment of the veteran to the specific facility.

Nursing Service believes it has a professional commitment to maintain an environment which permits the individual to maintain a satisfying self-image and attain his optimal level of independent function. This is achieved through activities which permit feelings of accomplishment, responsibility, and work as a person, a member of the family unit, and a member of the community.

Nursing Service continues to, (1) demonstrate the contributions nurses are making in expanded roles to improve care for the aged in a variety of settings, and (2) explore the influence of environment on the therapeutic program.

8. VOLUNTARY SERVICE

Voluntary Service is involved both with services to the aging veteran-patient and with service given by the older volunteer.

Staff concerned with programs of care for the geriatric patient or resident have found volunteers helpful in a wide range of services. Among the most effective volunteer roles in services to these patients have been those in companionship therapy, reality training, remotivation and resocialization, and as friendly visitors to VA patients in community care facilities.

Services and programs for geriatric patients have involved volunteers at many age levels, from senior citizen to college and high school students. In some instances, even younger volunteers have contributed to the morale of elderly long term care patients and residents through such activities as "Adopt a Grandparent" programs.

The older citizen as a volunteer has always been a mainstay of the VA Voluntary Service program and some individuals have remained active and effective into their nineties. There are few assignments unsuited to senior citizens and those relate chiefly to physical demands.

There are, however, a great many assignments where the older volunteer's maturity, experience, special qualifications, and availability when needed make them particularly valuable. Among the diversified activities in this category are those which involve teaching and counseling, the use of manual arts, hobby, technical, professional and homemaking skills.

Because the continued influx of older volunteers is essential to the program, Voluntary Service this year has maintained at the national level and enhanced at the hospital level its liaison with ACTION's Older American Volunteer Program. In addition, plans for closer liaison with the American Association of Retired Persons/National Retired Teachers Association will be implemented during the current fiscal year with the goal of encouraging even more older Americans to participate in VA Voluntary Service activities.

9. EDUCATION

The Office of Academic Affairs has been actively involved in planning a comprehensive educational program for health care workers involved in the treatment of geriatric patients. The approach that has been evolved is multifaceted, involving training of students and the continuing and in-service education of VA health professionals. The education will be accomplished through affiliation with University programs and the development of special VA short term courses. The development of video-tapes, film strips, manuals, bibliographies and other materials will be pursued in support of the programs.

It is expected that a major effort will be made to locate a significant portion of these training programs at the newly organized VA Geriatric Centers. This will enable the Centers to present a comprehensive program of education, research and patient care. However, since the need for training in geriatrics is so ubiquitous throughout the VA system, training activities will be initiated in multiple VA sites.

10. VA MEDICAL RESEARCH IN AGING—FISCAL YEAR 1974

In a recent symposium on behavior, aging and brain function, it was stated that the ". . . gerontological action is at the cell level" and that "man does not die of his diseases alone, but of his whole life."

These two quotations identify the boundaries of research on aging by the Veterans Administration. The research on aging cuts across all disciplines represented in the Medical Research Service and ranges from studies at the level of the cell to that of man and his environment. In addition to the experimental study of basic aging processes in many organ systems of the human, applied research is being conducted that is designed to ameliorate the medical and psychosocial problems associated with aging in man. Given the current state of knowledge about aging, the mission-oriented research program of the VA, and its mix of scientific and clinical expertise, this pluralism of research effort seems appropriate at this time.

The establishment of six Geriatric Research and Clinical Centers by the VA this year provides a unique combination of human services and research that is expected to have a major impact on the quality and direction of applied clinical research on aging. It will also stimulate basic research on aging.

Planning of the Geriatric Centers has made clear the need for an increase in studies on system of health care delivery employed by the VA. Sociologically oriented health care delivery research in the VA is both timely and urgent because of the current legislative interest in developing a national health care plan. The innovations in treatment proposed by the centers cover many aspects of service, e.g., alternatives to hospital care and therapeutic environments for psychiatric patients, and all need to be carefully evaluated.

The remainder of this report consists of selected examples of biomedical and behavioral research in aging completed during fiscal year 1974. The examples are organized approximately according to the level of complexity of the system described—cell, organ system, and intact man. In addition, the material is organized so that the description of the biological research precedes that of behavioral, and basic precedes applied.

About a third of the VA research projects currently reported concern biochemical studies of aging cells both in cultures and in living organisms. At Sepulveda, Calif., studies of mitochondrial DNA replication in mouse embryo tissue identified some RNA products transcribed from DNA. The role of the mitochondrial genome in the biogenesis of mitochondria appears to be the same in somatic and in cultured tissue cells. The aging phenomenon of these extranuclear components of the cell can be studied in tissue culture without recourse to living organisms.

Research in two laboratories attempted to alter the pattern of reproduction of cultured cells. At Martinez, Calif., research showed that including an antioxidant agent in the culture medium extends the in-vitro life span of cultured human normal cells. At Bedford, Mass., it was demonstrated that the growth of cultured connective tissue cells from older donors could be altered by exposing them to the blood serum of young donors. Chemical constituents from the younger cells crossed a filter to influence the growth of the older ones. The practical significance is not yet clear, but the capacity to manipulate the processes of cell growth and division by environmental intervention is an important scientific accomplishment.

The effects of aging on the accretion of materials in the cellular environment are being studied in several VA hospitals. At Downey, Ill., for example, the age-related increase in lysosome activity is being studied in the rat brain. The major hypothesis is that when this substance which is normally bound to the membrane of a central nervous system cell is released within the cell, disruption or cell-death may result. Hopefully, it may ultimately be possible to devise preventive techniques which may lead to the prevention of age-related cellular membrane disruption which at this time has been demonstrated only in experimental animals.

An investigation of age differences in the human aortic valve at Baltimore, Md., showed that the accumulation and calcification of intracellular matter, when extracted and deposited on the aortic valve, impairs its functioning. The research may result in an improved understanding of organ calcification and its deleterious effects as one grows older. At Long Beach, Calif., the aging on neurons in mice has been studied to determine the development of fatty pigments. At Pittsburgh, Pa., development studies of neutral fibrils around the axon of the sciatic nerve in rats showed changes between prepuberty and young animals but not between young animals and adulthood. The results of the latter study appear to show one functional deficit in neurons related to specific stages in life as opposed to a continuum of such deficits throughout life.

The study of age changes in connective and elastic tissue is of considerable practical as well as scientific importance. At Memphis, Tenn., studies of rheumatoid arthritis, an inflammatory disease of the joints, implicated abnormalities of lymphocytes and the metabolism of nucleotides in the disease process. In St. Louis, Mo., studies of elastin in the lung tissue of rats showed that this substance increases with age more in males than in females. This sex difference in elastin may be associated with the greater incidence of emphysema in males.

Data such as those just described are consistent with other findings which show that with aging, some resilient tissue is replaced by less pliable tissue. Examples include the age-related rigidity of blood vessels, and the increased density of the eye with age, leading respectively to cardiovascular disease and cataracts.

Studies of the relationships between diabetes and lipid metabolism on the one hand and aging and disease states on the other continued to receive attention in several VA hospitals. At Seattle, Wash., research is being conducted to evaluate the hypothesis that aging and diabetes in man impair cell metabolism in a similar way. Successful development of a tissue culture procedure makes it possible to compare the uptake of lipoproteins in cells from young and old normals and diabetics. The significance of such research for aging is that it will help to differentiate healthy aging from accelerated aging brought about by abnormal processing of fatty material and carbohydrates by the body.

At the Boston, Mass., VA Outpatient Clinic, patients with Huntington's disease showed the characteristic neural pathology and over half had impaired glucose tolerance. The neuroendocrine abnormalities in these patients who show signs of accelerated aging may improve our understanding of normal aging.

Age-related differences in the psychological processes of decision-making, learning and remembering are being studied in several VA laboratories. Research at Boston OPC demonstrated that age-related differences in the speed of retrieving memorized information are largest when information is newly-memorized and smallest when it is familiar. Research reported at Syracuse, N.Y., and Brentwood, California, demonstrate that there are few age-related differences in the types of strategies employed by persons to cope with various cognitive tasks.

Advances have been made in relating the speed of mental operations to the activity of the brain as measured by modern electroencephalography. A study at Salt Lake City, Utah, produced information on age differences in sensory-evoked responses in subjects ranging in age from infancy to 85 years. Similar information has been obtained for the stump-tailed macaque monkey. The availability of these norms will speed up the progress of research relating behavioral and physiological measures and will also facilitate the use of this information for clinical purposes.

The longitudinal, interdisciplinary studies of the biological and behavioral aging of healthy men continue at Boston OPC. Dozens of different studies are conducted by physicians, dentists, physical anthropologists, psychologists and sociologists.

Indices of aging based on biological and behavioral functioning are developing and during the past year several new indices were produced. X-ray observations of the ossification of the cartilage around the ribs proved to be an exceptionally accurate index of skeletal aging.

Detailed histories of the drinking and smoking habits of healthy men helped interpret the longitudinal findings of the study. It is now clear that pulmonary function declines with age. The amount of decline is nearly as large in nonsmokers as in those who smoke. Exsmokers had a higher blood pressure than those who continued to smoke. Some of the weight gain associated with cessation of smoking cigarettes could be attributed to the weight gain associated with aging. Association was found between the amount of periodontal disease and smoking, independently of age.

In the same study, research on the shrinkage of the visual field in old age continues. A relationship between the shrinkage of the visual field and diminished pulmonary function suggests that poor oxygen uptake contributes to the phenomenon. A variety of studies on blood gases and aging in normal males contrasted the changes of aging with the profound change observed in visual function and in mental performance under conditions of experimental oxygen deprivation and in high-altitude studies where there is also a considerable decrease in inspired oxygen.

Retirement research has shown that as individuals grow older, they tend to prefer later retirement. Another factor which augments this preference is level of education. These findings point up a dilemma in a society where retirement age is being lowered.

At Bay Pines, Fla., several biological and behavioral tests were made on a group of geriatric baseball players, elderly members of a bridge club, and other aging populations. On the average the old baseball players had superior psychomotor performance than their less physically active contemporaries but the pattern of cognitive abilities was almost the same in both groups. The amount of clinical pathology present in the old baseball players was almost the same as that of more sedentary groups, but their attitudes toward these problems and their morale was generally better. The findings suggest that maintenance of physical activity in old age may offset or retard age deficits in biological and behavioral functioning. Many of the measures employed were the same as those employed in the Normative Aging Study, thereby allowing some direct comparisons between older and younger groups.

A variety of research efforts directed at ameliorating medical and behavioral problems associated with old age are being conducted at various VA hospitals. A common problem associated with aging is osteoporosis. Development of improved treatment methods depends in part on measuring the utilization of calcium in skeletal tissue and VA scientists at Albany, N.Y., are working on several procedures to accomplish this, partly in collaboration with scientists at the Brookhaven National Laboratory.

Evaluation of the use of high pressure oxygen therapy to reverse the cognitive deficits associated with senile dementia continues at Buffalo, N.Y. Improved function was found in several aged patients with vascular insufficiency. A national board of advisors is working with VA researchers at Buffalo to improve the evaluation of oxygen therapy.

Research at St. Cloud, Minn., showed that death and illness of geriatric patients were very low in comparison with similar studies in private and church-sponsored retirement institutions. Another study at St. Cloud compared the effect of assigning patients to geriatric wards vs. placements in the community. Followup studies revealed the morale of the group placed in the community improved.

From the preceding, it is clear that the problem of aging both from a clinical and research point of view is important to VA investigators and rightly so because this type of clinical and research investigation represents an activity that VA investigators are singularly well-equipped to do.

DEPARTMENT OF VETERANS BENEFITS

1. COMPENSATION AND PENSION PROGRAMS

The Veterans Administration, through the various programs administered by the Department of Veterans Benefits (compensation, pension and dependency and indemnity compensation) provides all or part of the income for 1,666,350 persons age 65 or older. This total is broken down to 813,209 veterans, 691,953 widows, 123,895 mothers and 37,293 fathers of veterans.

2. VETERANS ASSISTANCE SERVICE

In 1974, the Veterans Assistance Service-Guardianship activity completed its third full year of application of supervised direct payment procedures whereby marginally functioning VA beneficiaries, persons classified as incompetent but deemed borderline between competency and incompetency, are paid direct with supervision. When payments are made directly to such incompetent beneficiaries, frequent personal contacts are made to evaluate their status. If a beneficiary deteriorates to the point where a fiduciary is necessary, one is obtained. On the other hand, if a beneficiary improves to the point where a competency classification seems in order, effort is made to have him so declared. Supervised direct payment procedures are providing the degree of assistance the individual beneficiary requires and still leave him a free and unencumbered member of society.

The toll-free telephone system FX (Foreign Exchange) and WATS (Wide Area Telephone Service) has made it easier for the aged to receive VA assistance regarding benefits to which they may be entitled. Approximately 90% of the population can now talk toll-free to a Veterans Benefits Counselor in our regional offices. This means that it no longer is necessary for veterans or members of his family to travel to one of our offices or pay for a long distance call in order to obtain information or help on VA benefits.

The VA mobile van program was initiated to aid in implementing the outreach program by going to those persons located in rural areas. The Veterans Benefits Counselors, who man the mobile vans, are aware of the special economic and health needs of the aged and where claims for benefits have not been made, solicit and assist in initiating claims for veterans' benefits.

Veterans Benefits Counselors stationed all across the nation are aware of the special application of VA monetary and service programs to the problems of the aging. These VA representatives not only counsel the potential beneficiaries on the availability of the service but assist them in applying for the benefits.

3. EDUCATIONAL ASSISTANCE

There are about 1,051 people over age 65 receiving Veterans Administration educational benefits. Seven hundred nineteen persons are attending training under chapter 34, title 38, United States Code, receiving benefits designated by the Veterans Readjustment Act of 1966 as amended. In addition 142 widows of veterans who died of service-connected causes and wives of veterans who are permanently and totally disabled from service-connected disabilities are enrolled in the education program under chapter 35. About 190 are recipients of vocational rehabilitation benefits under chapter 31.

Appendix 5

COMMITTEE HEARINGS AND REPORTS

No asterisk indicates single copy available from committee and multiple copies available for purchase from U.S. Government Printing Office.

One asterisk indicates committee's supply exhausted; copies are available for purchase from Superintendent of Documents, Government Printing Office, Washington, D.C. 20402.

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Three asterisks indicate limited quantity, single copy available from committee supply.

With a request for printed copies of documents, please enclose self-addressed label for each item desired.

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  Part 5. Springfield, Mass., November 29, 1961.
  Part 6. St. Joseph, Mo., December 11, 1961.
  Part 7. Hannibal, Mo., December 13, 1961.
  Part 8. Cape Girardeau, Mo., December 15, 1961.
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  Part 10. Fort Lauderdale, Fla., February 15, 1962.

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  Part 3. Los Angeles, Calif., October 24, 1961.
  Part 4. Las Vegas, Nev., October 25, 1961.

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  - Part 6. Pocatello, Idaho, November 13, 1961.
  - Part 7. Boise, Idaho, November 15, 1961.
  - Part 8. Spokane, Wash., November 17, 1961.
  - Part 9. Honolulu, Hawaii, November 27, 1961.
  - Part 10. Lihue, Hawaii, November 29, 1961.
  - Part 11. Wailuku, Hawaii, November 30, 1961.
  - Part 12. Hilo, Hawaii, December 1, 1961.
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  - Part 2. Newark, N.J., October 16, 1961.
  - Part 3. Philadelphia, Pa., October 18, 1961.
  - Part 4. Scranton, Pa., November 14, 1961.
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  - Part 1. Portland, Oreg., November 6, 1961.
  - Part 2. Walla Walla, Wash., November 10, 1961.
  - Part 3. Hartford, Conn., November 20, 1961.
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- Consumer Interests of the Elderly:**
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